Major Depressive Disorder, With Catatonic Features. Prior history or family history may be helpful in making this distinction.

In elderly individuals, 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 in Major Depressive Disorder. This differential diagnosis may be informed by a thorough general medical evaluation and consideration of the onset of the disturbance, temporal sequencing of depressive and cognitive symptoms, course of illness, and treatment response. The premorbid state of the individual may help to differentiate a Major Depressive Disorder from dementia. In dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with Major Depressive Disorder is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Diagnostic criteria for 296.2x Major Depressive Disorder, Single Episode

A. Presence of a single Major Depressive Episode (see p. 356).

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

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, *specify* the current clinical status of the Major Depressive Disorder or 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)

Diagnostic criteria for 296.3x Major Depressive Disorder, Recurrent

A. Presence of two or more Major Depressive Episodes (see p. 356).

Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

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, *specify* the current clinical status of the Major Depressive Disorder or 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)

Specify:

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

300.4 Dysthymic Disorder

Diagnostic Features

The essential feature of Dysthymic Disorder is a chronically depressed mood that occurs for most of the day more days than not for at least 2 years (Criterion A). Individ-

uals with Dysthymic Disorder describe their mood as sad or "down in the dumps." In children, the mood may be irritable rather than depressed, and the required minimum duration is only 1 year. During periods of depressed mood, at least two of the following additional symptoms are present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness (Criterion B). Individuals may note the prominent presence of low interest and self-criticism, often seeing themselves as uninteresting or incapable. Because these symptoms have become so much a part of the individual's day-to-day experience (e.g., "I've always been this way," "That's just how I am"), they are often not reported unless directly asked about by the interviewer.

During the 2-year period (1 year for children or adolescents), any symptom-free intervals last no longer than 2 months (Criterion C). The diagnosis of Dysthymic Disorder can be made only if the initial 2-year period of dysthymic symptoms is free of Major Depressive Episodes (Criterion D). If the chronic depressive symptoms include a Major Depressive Episode during the initial 2 years, then the diagnosis is Major Depressive Disorder, Chronic (if full criteria for a Major Depressive Episode are met), or Major Depressive Disorder, In Partial Remission (if full criteria for a Major Depressive Episode are not currently met). After the initial 2 years of the Dysthymic Disorder, Major Depressive Episodes may be superimposed on the Dysthymic Disorder. In such cases ("double depression"), both Major Depressive Disorder and Dysthymic Disorder are diagnosed. Once the person returns to a dysthymic baseline (i.e., criteria for a Major Depressive Episode are no longer met but dysthymic symptoms persist), only Dysthymic Disorder is diagnosed.

The diagnosis of Dysthymic Disorder is not made if the individual has ever had a Manic Episode (p. 357), a Mixed Episode (p. 362), or a Hypomanic Episode (p. 365) or if criteria have ever been met for Cyclothymic Disorder (Criterion E). A separate diagnosis of Dysthymic Disorder is not made if the depressive symptoms occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder (Criterion F), in which case they are regarded as associated features of these disorders. Dysthymic Disorder is also not diagnosed if the disturbance is due to the direct physiological effects of a substance (e.g., alcohol, antihypertensive medications) or a general medical condition (e.g., hypothyroidism, Alzheimer's disease) (Criterion G). The symptoms must cause clinically significant distress or impairment in social, occupational (or academic), or other important areas of functioning (Criterion H).

Specifiers

Age at onset and the characteristic pattern of symptoms in Dysthymic Disorder may be indicated by using the following specifiers:

Early Onset. This specifier should be used if the onset of the dysthymic symptoms occurs before age 21 years. Such individuals are more likely to develop subsequent Major Depressive Episodes.

Late Onset. This specifier should be used if the onset of the dysthymic symptoms occurs at age 21 or older.

With Atypical Features. This specifier should be used if the pattern of symp-

toms during the most recent 2 years of the disorder meets the criteria for With Atypical Features (see p. 420).

Associated Features and Disorders

Associated descriptive features and mental disorders. The associated features of Dysthymic Disorder are similar to those for a Major Depressive Episode (p. 352). Several studies suggest that the most commonly encountered symptoms in Dysthymic Disorder may be feelings of inadequacy; generalized loss of interest or pleasure; social withdrawal; feelings of guilt or brooding about the past; subjective feelings of irritability or excessive anger; and decreased activity, effectiveness, or productivity. (Appendix B provides an alternative for Criterion B for use in research studies that includes these items.) In individuals with Dysthymic Disorder, vegetative symptoms (e.g., sleep, appetite, weight change, and psychomotor symptoms) appear to be less common than for persons in a Major Depressive Episode. When Dysthymic Disorder without prior Major Depressive Disorder is present, it is a risk factor for developing Major Depressive Disorder (in clinical settings up to 75% of individuals with Dysthymic Disorder will develop Major Depressive Disorder within 5 years). Dysthymic Disorder may be associated with Borderline, Histrionic, Narcissistic, Avoidant, and Dependent Personality Disorders. However, the assessment of features of a Personality Disorder is difficult in such individuals because chronic mood symptoms may contribute to interpersonal problems or be associated with distorted self-perception. Other chronic Axis I disorders (e.g., Substance Dependence) or chronic psychosocial stressors may be associated with Dysthymic Disorder in adults. In children, Dysthymic Disorder may be associated with Attention-Deficit/Hyperactivity Disorder, Conduct Disorder, Anxiety Disorders, Learning Disorders, and Mental Retardation.

Associated laboratory findings. About 25%–50% of adults with Dysthymic Disorder have some of the same polysomnographic features that are found in some individuals with Major Depressive Disorder (e.g., reduced rapid eye movement [REM] latency, increased REM density, reduced slow-wave sleep, impaired sleep continuity). Those individuals with polysomnographic abnormalities more often have a positive family history for Major Depressive Disorder (and may respond better to antidepressant medications) than those with Dysthymic Disorder without such findings. Whether polysomnographic abnormalities are also found in those with "pure" Dysthymic Disorder (i.e., those with no prior history of Major Depressive Episodes) is not clear. Dexamethasone nonsuppression in Dysthymic Disorder is not common, unless criteria are also met for a Major Depressive Episode.

Specific Age and Gender Features

In children, Dysthymic Disorder seems to occur equally in both sexes and often results in impaired school performance and social interaction. Children and adolescents with Dysthymic Disorder are usually irritable and cranky as well as depressed. They have low self-esteem and poor social skills and are pessimistic. In adulthood, women are two to three times more likely to develop Dysthymic Disorder than are men.

Prevalence

The lifetime prevalence of Dysthymic Disorder (with or without superimposed Major Depressive Disorder) is approximately 6%. The point prevalence of Dysthymic Disorder is approximately 3%.

Course

Dysthymic Disorder often has an early and insidious onset (i.e., in childhood, adolescence, or early adult life) as well as a chronic course. In clinical settings, individuals with Dysthymic Disorder usually have superimposed Major Depressive Disorder, which is often the reason for seeking treatment. If Dysthymic Disorder precedes the onset of Major Depressive Disorder, there is less likelihood that there will be spontaneous full interepisode recovery between Major Depressive Episodes and a greater likelihood of having more frequent subsequent episodes. Although the spontaneous remission rate for Dysthymic Disorder may be as low as 10% per year, evidence suggests the outcome is significantly better with active treatment. The treated course of Dysthymic Disorder appears similar to that of other Depressive Disorders, whether or not there is a superimposed Major Depressive Disorder.

Familial Pattern

Dysthymic Disorder is more common among first-degree biological relatives of people with Major Depressive Disorder than among the general population. In addition, both Dysthymic Disorder and Major Depressive Disorder are more common in the first-degree relatives of individuals with Dysthymic Disorder.

Differential Diagnosis

See the "Differential Diagnosis" section for Major Depressive Disorder (p. 373). The differential diagnosis between Dysthymic Disorder and **Major Depressive Disorder** is made particularly difficult by the facts 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. When Dysthymic Disorder is of many years' duration, the mood disturbance may not be easily distinguished from the person's "usual" functioning. If the initial onset of chronic depressive symptoms is of sufficient severity and number to meet full criteria for a Major Depressive Episode, the diagnosis would be Major Depressive Disorder, Chronic (if the full criteria are still met), or Major Depressive Disorder, In Partial Remission (if the full criteria are no longer met). The diagnosis of Dysthymic Disorder can be 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 Disorder (i.e., lasting at least 2 months) before the onset of the Dysthymic Disorder.

Depressive symptoms may be a common associated feature of **chronic Psychotic Disorders** (e.g., Schizoaffective Disorder, Schizophrenia, Delusional Disorder). A separate diagnosis of Dysthymic Disorder is not made if the symptoms occur only during the course of the Psychotic Disorder (including residual phases).

Dysthymic 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, With Depressive Features, if the mood disturbance is judged to be the direct physiological consequence of a specific, usually chronic, general medical condition (e.g., multiple sclerosis) (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., Dysthymic Disorder) and the general medical condition is recorded on Axis III (e.g., diabetes mellitus). This would be the case, for example, if the depressive symptoms are considered to be the psychological consequence of having a chronic general medical condition or if there is no etiological relationship between the depressive symptoms and the general medical condition. A **Substance-Induced Mood Disorder** is distinguished from a Dysthymic 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).

Often there is evidence of a **coexisting personality disturbance**. When an individual's presentation meets the criteria for both Dysthymic Disorder and a Personality Disorder, both diagnoses are given.

Diagnostic criteria for 300.4 Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be irritable and duration must be at least 1 year.

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

  (1) poor appetite or overeating
  (2) insomnia or hypersomnia
  (3) low energy or fatigue
  (4) low self-esteem
  (5) poor concentration or difficulty making decisions
  (6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode (see p. 356) has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

Diagnostic criteria for 300.4 Dysthymic Disorder *(continued)*

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368), and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. 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).

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

Specify if:

Early Onset: if onset is before age 21 years
Late Onset: if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

With Atypical Features (see p. 420)

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311 Depressive Disorder Not Otherwise Specified

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood (see p. 679), or Adjustment Disorder With Mixed Anxiety and Depressed Mood (see p. 680). Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified (see p. 484). Examples of Depressive Disorder Not Otherwise Specified include

1. Premenstrual dysphoric disorder: in most menstrual cycles during the past year, symptoms (e.g., markedly depressed mood, marked anxiety, marked affective lability, decreased interest in activities) regularly occurred during the last week of the luteal phase (and remitted within a few days of the onset of menses). These symptoms must be severe enough to markedly interfere with work, school, or usual activities and be entirely absent for at least 1 week postmenses (see p. 771 for suggested research criteria).
2. Minor depressive disorder: episodes of at least 2 weeks of depressive symptoms but with fewer than the five items required for Major Depressive Disorder (see p. 775 for suggested research criteria).

3. Recurrent brief depressive disorder: depressive episodes lasting from 2 days up to 2 weeks, occurring at least once a month for 12 months (not associated with the menstrual cycle) (see p. 778 for suggested research criteria).
4. Postpsychotic depressive disorder of Schizophrenia: a Major Depressive Episode that occurs during the residual phase of Schizophrenia (see p. 767 for suggested research criteria).
5. A Major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder Not Otherwise Specified, or the active phase of Schizophrenia.
6. Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.

Bipolar Disorders

This section includes Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified. There are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified. Bipolar I Disorder, Single Manic Episode, is used to describe individuals who are having a first episode of mania. The remaining criteria sets are used to specify the nature of the current (or most recent) episode in individuals who have had recurrent mood episodes.

Bipolar I Disorder

Diagnostic Features

The essential feature of Bipolar I Disorder is a clinical course that is characterized by the occurrence of one or more Manic Episodes (see p. 357) or Mixed Episodes (see p. 362). Often individuals have also had one or more Major Depressive Episodes (see p. 349). Episodes of Substance-Induced Mood Disorder (due to the direct effects of a medication, other somatic treatments for depression, a drug of abuse, or toxin exposure) or of Mood Disorder Due to a General Medical Condition do not count toward a diagnosis of Bipolar I Disorder. In addition, the episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified. Bipolar I Disorder is subclassified in the fourth digit of the code according to whether the individual is experiencing a first episode (i.e., Single Manic Episode) or whether the disorder is recurrent. Recurrence is indicated by either a shift in the polarity of the episode or an interval between episodes of at least 2 months without manic symptoms. A shift in polarity is defined as a clinical course in which a Major Depressive Episode evolves into a Manic Episode or a Mixed Episode or in which a Manic Episode or a Mixed Episode evolves into a Major Depressive Episode. In contrast, a Hypomanic Episode that evolves into a Manic Episode or a Mixed Epi-

sode, or a Manic Episode that evolves into a Mixed Episode (or vice versa), is considered to be only a single episode. For recurrent Bipolar I Disorders, the nature of the current (or most recent) episode can be specified (Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, Most Recent Episode Unspecified).

Specifiers

If the full criteria are currently met for a Manic, Mixed, or 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)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

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

In Partial Remission, In Full Remission (see p. 411)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

If criteria are currently met for a Major Depressive Episode, the following may be used to describe features of the current episode (or, if criteria are not currently met but the most recent episode of Bipolar I Disorder was a Major Depressive Episode, these specifiers apply to that episode):

Chronic (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)

The following specifiers can be used to indicate the pattern of episodes:

Longitudinal Course Specifiers (With and Without Full Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Recording Procedures

The diagnostic codes for Bipolar I Disorder are selected as follows:

1. The first three digits are 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 Dis-

order 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, 5 if it is a Major Depressive Episode, 6 if it is a Mixed 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. Other specifiers for Bipolar I Disorder cannot be coded. 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.

In recording the name of a diagnosis, terms should be listed in the following order: Bipolar I Disorder, specifiers coded in the fourth digit (e.g., Most Recent Episode Manic), 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 Rapid Cycling); for example, 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features, With Melancholic Features, With Rapid Cycling.

Note that if the single episode of Bipolar I Disorder is a Mixed Episode, the diagnosis would be indicated as 296.0x Bipolar I Disorder, Single Manic Episode, Mixed.

Associated Features and Disorders

Associated descriptive features and mental disorders. Completed suicide occurs in 10%–15% of individuals with Bipolar I Disorder. Suicidal ideation and attempts are more likely to occur when the individual is in a depressive or mixed state. Child abuse, spouse abuse, or other violent behavior may occur during severe Manic Episodes or during those with psychotic features. Other associated problems include school truancy, school failure, occupational failure, divorce, or episodic antisocial behavior. Bipolar Disorder is associated with Alcohol and other Substance Use Disorders in many individuals. Individuals with earlier onset of Bipolar I Disorder are more likely to have a history of current alcohol or other substance use problems. Concomitant alcohol and other substance use is associated with an increased number of hospitalizations and a worse course of illness. Other associated mental disorders include Anorexia Nervosa, Bulimia Nervosa, Attention-Deficit/Hyperactivity Disorder, Panic Disorder, and Social Phobia.

Associated laboratory findings. There appear to be no laboratory features that are diagnostic of Bipolar I Disorder or that distinguish Major Depressive Episodes found in Bipolar I Disorder from those in Major Depressive Disorder or Bipolar II Disorder.

Imaging studies comparing groups of individuals with Bipolar I Disorder with groups with Major Depressive Disorder or groups without any Mood Disorder tend to show increased rates of right-hemispheric lesions, or bilateral subcortical or periventricular lesions in those with Bipolar I Disorder.

Associated physical examination findings and general medical conditions. An age at onset for a first Manic Episode after age 40 years should alert the clinician to the possibility that the symptoms may be due to a general medical condition or substance use. Current or past hypothyroidism or laboratory evidence of mild thyroid hypofunction may be associated with Rapid Cycling (see p. 427). In addition, hyperthyroidism may precipitate or worsen manic symptoms in individuals with a preexisting Mood Disorder. However, hyperthyroidism in individuals without preexisting Mood Disorder does not typically cause manic symptoms.

Specific Culture, Age, and Gender Features

There are no reports of differential incidence of Bipolar I Disorder based on race or ethnicity. There is some evidence that clinicians may have a tendency to overdiagnose Schizophrenia (instead of Bipolar Disorder) in some ethnic groups and in younger individuals.

Approximately 10%–15% of adolescents with recurrent Major Depressive Episodes will go on to develop Bipolar I Disorder. Mixed Episodes appear to be more likely in adolescents and young adults than in older adults.

Recent epidemiological studies in the United States indicate that Bipolar I Disorder is approximately equally common in men and women (unlike Major Depressive Disorder, which is more common in women). Gender appears to be related to the number and type of Manic and Major Depressive Episodes. The first episode in males is more likely to be a Manic Episode. The first episode in females is more likely to be a Major Depressive Episode. In men the number of Manic Episodes equals or exceeds the number of Major Depressive Episodes, whereas in women Major Depressive Episodes predominate. In addition, Rapid Cycling (see p. 427) is more common in women than in men. Some evidence suggests that mixed or depressive symptoms during Manic Episodes may be more common in women as well, although not all studies are in agreement. Thus, women may be at particular risk for depressive or intermixed mood symptoms. Women with Bipolar I Disorder have an increased risk of developing subsequent episodes in the immediate postpartum period. Some women have their first episode during the postpartum period. The specifier With Postpartum Onset may be used to indicate that the onset of the episode is within 4 weeks of delivery (see p. 422). The premenstrual period may be associated with worsening of an ongoing Major Depressive, Manic, Mixed, or Hypomanic Episode.

Prevalence

The lifetime prevalence of Bipolar I Disorder in community samples has varied from 0.4% to 1.6%.

Course

Average age at onset is 20 for both men and women. Bipolar I Disorder is a recurrent disorder—more than 90% of individuals who have a single Manic Episode go on to have future episodes. Roughly 60%–70% of Manic Episodes occur immediately before or after a Major Depressive Episode. Manic Episodes often precede or follow the Major Depressive Episodes in a characteristic pattern for a particular person. The number of lifetime episodes (both Manic and Major Depressive) tends to be higher for Bipolar I Disorder compared with Major Depressive Disorder, Recurrent. Studies of the course of Bipolar I Disorder prior to lithium maintenance treatment suggest that, on average, four episodes occur in 10 years. The interval between episodes tends to decrease as the individual ages. There is some evidence that changes in sleep-wake schedule such as occur during time zone changes or sleep deprivation may precipitate or exacerbate a Manic, Mixed, or Hypomanic Episode. Approximately 5%–15% of individuals with Bipolar I Disorder have multiple (four or more) mood episodes (Major Depressive, Manic, Mixed, or Hypomanic) that occur within a given year. If this pattern is present, it is noted by the specifier With Rapid Cycling (see p. 427). A rapid-cycling pattern is associated with a poorer prognosis.

Although the majority of individuals with Bipolar I Disorder experience significant symptom reduction between episodes, some (20%–30%) continue to display mood lability and other residual mood symptoms. As many as 60% experience chronic interpersonal or occupational difficulties between acute episodes. Psychotic symptoms may develop after days or weeks in what was previously a nonpsychotic Manic or Mixed Episode. When an individual has Manic Episodes with psychotic features, subsequent Manic Episodes are more likely to have psychotic features. Incomplete interepisode recovery is more common when the current episode is accompanied by mood-incongruent psychotic features.

Familial Pattern

First-degree biological relatives of individuals with Bipolar I Disorder have elevated rates of Bipolar I Disorder (4%–24%), Bipolar II Disorder (1%–5%), and Major Depressive Disorder (4%–24%). Those individuals with Mood Disorder in their first-degree biological relatives are more likely to have an earlier age at onset. Twin and adoption studies provide strong evidence of a genetic influence for Bipolar I Disorder.

Differential Diagnosis

Major Depressive, Manic, Mixed, and Hypomanic Episodes in Bipolar I Disorder must be distinguished from episodes of a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are 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.

A **Substance-Induced Mood Disorder** is distinguished from Major Depressive, Manic, or Mixed Episodes that occur in Bipolar I 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). Symptoms like those seen in a Manic,

Mixed, or Hypomanic Episode may be part of an intoxication with or withdrawal from a drug of abuse and should be diagnosed as a Substance-Induced Mood Disorder (e.g., euphoric mood that occurs 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 or Mixed Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes may be diagnosed as a Substance-Induced Mood Disorder (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features) and would not count toward a diagnosis of Bipolar I Disorder. However, when the substance use or medication is judged not to fully account for the episode (e.g., the episode continues for a considerable period autonomously after the substance is discontinued), the episode would count toward a diagnosis of Bipolar I Disorder.

Bipolar I Disorder is distinguished from **Major Depressive Disorder** and **Dysthymic Disorder** by the lifetime history of at least one Manic or Mixed Episode. Bipolar I Disorder is distinguished from **Bipolar II Disorder** by the presence of one or more Manic or Mixed Episodes. When an individual previously diagnosed with Bipolar II Disorder develops a Manic or Mixed Episode, the diagnosis is changed to Bipolar I Disorder.

In **Cyclothymic Disorder,** there are numerous periods of hypomanic symptoms that do not meet criteria for a Manic Episode and periods of depressive symptoms that do not meet symptom or duration criteria for a Major Depressive Episode. Bipolar I Disorder is distinguished from Cyclothymic Disorder by the presence of one or more Manic or Mixed Episodes. If a Manic or Mixed Episode occurs after the first 2 years of Cyclothymic Disorder, then Cyclothymic Disorder and Bipolar I Disorder may both be diagnosed.

The differential diagnosis between **Psychotic Disorders** (e.g., Schizoaffective Disorder, Schizophrenia, and Delusional Disorder) and Bipolar I Disorder may be difficult (especially in adolescents) because these disorders may share a number of presenting symptoms (e.g., grandiose and persecutory delusions, irritability, agitation, and catatonic symptoms), particularly cross-sectionally and early in their course. In contrast to Bipolar I Disorder, Schizophrenia, Schizoaffective Disorder, and Delusional Disorder are all characterized by periods of psychotic symptoms that occur in the absence of prominent mood symptoms. Other helpful considerations include the accompanying symptoms, previous course, and family history. Manic and depressive symptoms may be present during Schizophrenia, Delusional Disorder, and Psychotic Disorder Not Otherwise Specified, but rarely with sufficient number, duration, and pervasiveness to meet criteria for a Manic Episode or a Major Depressive Episode. However, when full criteria are met (or the symptoms are of particular clinical significance), a diagnosis of **Bipolar Disorder Not Otherwise Specified** may be made in addition to the diagnosis of Schizophrenia, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

If there is a very rapid alternation (over days) between manic symptoms and depressive symptoms (e.g., several days of purely manic symptoms followed by several days of purely depressive symptoms) that do not meet minimal duration criteria for a Manic Episode or Major Depressive Episode, the diagnosis is **Bipolar Disorder Not Otherwise Specified.**

Diagnostic criteria for 296.0x Bipolar I Disorder, Single Manic Episode

A. Presence of only one Manic Episode (see p. 362) and no past Major Depressive Episodes.

Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.

B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify if:

Mixed: if symptoms meet criteria for a Mixed Episode (see p. 365)

If the full criteria are currently met for a Manic, Mixed, or Major Depressive Episode *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 410)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Manic, Mixed, or Major Depressive Episode, *specify* the current clinical status of the Bipolar I Disorder or features of the most recent episode:

In Partial Remission, In Full Remission (see p. 410)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

Diagnostic criteria for 296.40 Bipolar I Disorder, Most Recent Episode Hypomanic

A. Currently (or most recently) in a Hypomanic Episode (see p. 368).

B. There has previously been at least one Manic Episode (see p. 362) or Mixed Episode (see p. 365).

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

D. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Diagnostic criteria for 296.4x Bipolar I Disorder, Most Recent Episode Manic

A. Currently (or most recently) in a Manic Episode (see p. 362).

B. There has previously been at least one Major Depressive Episode (see p. 356), Manic Episode (see p. 362), or Mixed Episode (see p. 365).

C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

If the full criteria are currently met for a Manic Episode, *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 413)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Manic Episode, *specify* the current clinical status of the Bipolar I Disorder and/or features of the most recent Manic Episode:

In Partial Remission, In Full Remission (see p. 414)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Diagnostic criteria for 296.6x Bipolar I Disorder, Most Recent Episode Mixed

A. Currently (or most recently) in a Mixed Episode (see p. 365).

B. There has previously been at least one Major Depressive Episode (see p. 356), Manic Episode (see p. 362), or Mixed Episode (see p. 365).

C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

If the full criteria are currently met for a Mixed Episode, *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 415)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Mixed Episode, *specify* the current clinical status of the Bipolar I Disorder and/or features of the most recent Mixed Episode:

In Partial Remission, In Full Remission (see p. 416)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Diagnostic criteria for 296.5x Bipolar I Disorder, Most Recent Episode Depressed

A. Currently (or most recently) in a Major Depressive Episode (see p. 356).

B. There has previously been at least one Manic Episode (see p. 362) or Mixed Episode (see p. 365).

C. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

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, *specify* the current clinical status of the Bipolar I Disorder and/or features of the most recent Major Depressive 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)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Diagnostic criteria for 296.7 Bipolar I Disorder, Most Recent Episode Unspecified

A. Criteria, except for duration, are currently (or most recently) met for a Manic (see p. 362), a Hypomanic (see p. 368), a Mixed (see p. 365), or a Major Depressive Episode (see p. 356).

B. There has previously been at least one Manic Episode (see p. 362) or Mixed Episode (see p. 365).

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

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The mood symptoms in Criteria A and B 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).

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

296.89 Bipolar II Disorder (Recurrent Major Depressive Episodes With Hypomanic Episodes)

Diagnostic Features

The essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes (Criterion A) accompanied by at least one Hypomanic Episode (Criterion B). Hypomanic Episodes should not be confused with the several days of euthymia that may follow remission of a Major Depressive Episode. The presence of a Manic or Mixed Episode precludes the diagnosis of Bipolar II Disorder (Criterion C). Episodes of Substance-Induced Mood Disorder (due to the direct physiological effects of a medication, other somatic treatments for depression, drugs of abuse, or toxin exposure) or of Mood Disorder Due to a General Medical Condition do not count toward a diagnosis of Bipolar II 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 D). The symptoms must cause clinically significant distress or impairment in social, occupational, or oth-

er important areas of functioning (Criterion E). In some cases, the Hypomanic Episodes themselves do not cause impairment. Instead, the impairment may result from the Major Depressive Episodes or from a chronic pattern of unpredictable mood episodes and fluctuating unreliable interpersonal or occupational functioning.

Individuals with Bipolar II Disorder may not view the Hypomanic Episodes as pathological, although others may be troubled by the individual's erratic behavior. Often individuals, particularly when in the midst of a Major Depressive Episode, do not recall periods of hypomania without reminders from close friends or relatives. Information from other informants is often critical in establishing the diagnosis of Bipolar II Disorder.

Specifiers

The following specifiers for Bipolar II Disorder should be used to indicate the nature of the current episode or, if the full criteria are not currently met for a Hypomanic or Major Depressive Episode, the nature of the most recent episode:

Hypomanic. This specifier is used if the current (or most recent) episode is a Hypomanic Episode.
Depressed. This specifier is used if the current (or most recent) episode is a Major Depressive Episode.

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 Hypomanic or Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the Bipolar II Disorder and to describe features of the most recent Major Depressive Episode (only if it is the most recent type of mood 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 or frequency of episodes:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

Recording Procedures

The diagnostic code for Bipolar II Disorder is 296.89; none of the specifiers are codable. In recording the name of the diagnosis, terms should be listed in the following order: Bipolar II Disorder, specifiers indicating current or most recent episode (e.g., Hypomanic, Depressed), severity specifiers that apply to the current Major Depressive Episode (e.g., Moderate), as many specifiers describing features as apply to the current or most recent Major Depressive Episode (e.g., With Melancholic Features, With Postpartum Onset), and as many specifiers as apply to the course of episodes (e.g., With Seasonal Pattern); for example, 296.89 Bipolar II Disorder, Depressed, Severe With Psychotic Features, With Melancholic Features, With Seasonal Pattern.

Associated Features and Disorders

Associated descriptive features and mental disorders. Completed suicide (usually during Major Depressive Episodes) is a significant risk, occurring in 10%–15% of persons with Bipolar II Disorder. School truancy, school failure, occupational failure, or divorce may be associated with Bipolar II Disorder. Associated mental disorders include Substance Abuse or Dependence, Anorexia Nervosa, Bulimia Nervosa, Attention-Deficit/Hyperactivity Disorder, Panic Disorder, Social Phobia, and Borderline Personality Disorder.

Associated laboratory findings. There appear to be no laboratory features that are diagnostic of Bipolar II Disorder or that distinguish Major Depressive Episodes found in Bipolar II Disorder from those in Major Depressive Disorder or Bipolar I Disorder.

Associated physical examination findings and general medical conditions. An age at onset for a first Hypomanic Episode after age 40 years should alert the clinician to the possibility that the symptoms may be due to a general medical condition or substance use. Current or past hypothyroidism or laboratory evidence of mild thyroid hypofunction may be associated with Rapid Cycling (see p. 427). In addition, hyperthyroidism may precipitate or worsen hypomanic symptoms in individuals with a preexisting Mood Disorder. However, hyperthyroidism in other individuals does not typically cause hypomanic symptoms.

Specific Gender Features

Bipolar II Disorder may be more common in women than in men. Gender appears to be related to the number and type of Hypomanic and Major Depressive Episodes. In men the number of Hypomanic Episodes equals or exceeds the number of Major Depressive Episodes, whereas in women Major Depressive Episodes predominate. In

addition, Rapid Cycling (see p. 427) is more common in women than in men. Some evidence suggests that mixed or depressive symptoms during Hypomanic Episodes may be more common in women as well, although not all studies are in agreement. Thus, women may be at particular risk for depressive or intermixed mood symptoms. Women with Bipolar II Disorder may be at increased risk of developing subsequent episodes in the immediate postpartum period.

Prevalence

Community studies suggest a lifetime prevalence of Bipolar II Disorder of approximately 0.5%.

Course

Roughly 60%–70% of the Hypomanic Episodes in Bipolar II Disorder occur immediately before or after a Major Depressive Episode. Hypomanic Episodes often precede or follow the Major Depressive Episodes in a characteristic pattern for a particular person. The number of lifetime episodes (both Hypomanic Episodes and Major Depressive Episodes) tends to be higher for Bipolar II Disorder compared with Major Depressive Disorder, Recurrent. The interval between episodes tends to decrease as the individual ages. Approximately 5%–15% of individuals with Bipolar II Disorder have multiple (four or more) mood episodes (Hypomanic or Major Depressive) that occur within a given year. If this pattern is present, it is noted by the specifier With Rapid Cycling (see p. 427). A rapid-cycling pattern is associated with a poorer prognosis.

Although the majority of individuals with Bipolar II Disorder return to a fully functional level between episodes, approximately 15% continue to display mood lability and interpersonal or occupational difficulties. Psychotic symptoms do not occur in Hypomanic Episodes, and they appear to be less frequent in the Major Depressive Episodes in Bipolar II Disorder than is the case for Bipolar I Disorder. Some evidence is consistent with the notion that marked changes in sleep-wake schedule such as occur during time zone changes or sleep deprivation may precipitate or exacerbate Hypomanic or Major Depressive Episodes. If a Manic or Mixed Episode develops in the course of Bipolar II Disorder, the diagnosis is changed to Bipolar I Disorder. Over 5 years, about 5%–15% of individuals with Bipolar II Disorder will develop a Manic Episode.

Familial Pattern

Some studies have indicated that first-degree biological relatives of individuals with Bipolar II Disorder have elevated rates of Bipolar II Disorder, Bipolar I Disorder, and Major Depressive Disorder compared with the general population.

Differential Diagnosis

Hypomanic and Major Depressive Episodes in Bipolar II Disorder must be distinguished from episodes of a **Mood Disorder Due to a General Medical Condition.**

The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are 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.

A **Substance-Induced Mood Disorder** is distinguished from Hypomanic or Major Depressive Episodes that occur in Bipolar II 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). Symptoms like those seen in a Hypomanic Episode may be part of an intoxication with or withdrawal from a drug of abuse and should be diagnosed as a Substance-Induced Mood Disorder (e.g., a major depressive–like episode occurring only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal). 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 may be diagnosed as a Substance-Induced Mood Disorder (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features) and would not count toward a diagnosis of Bipolar II Disorder. However, when the substance use or medication is judged not to fully account for the episode (e.g., the episode continues for a considerable period autonomously after the substance is discontinued), the episode would count toward a diagnosis of Bipolar II Disorder.

Bipolar II Disorder is distinguished from **Major Depressive Disorder** by the lifetime history of at least one Hypomanic Episode. Attention during the interview to whether there is a history of euphoric or dysphoric hypomania is important in making a differential diagnosis. Bipolar II Disorder is distinguished from **Bipolar I Disorder** by the presence of one or more Manic or Mixed Episodes in the latter. When an individual previously diagnosed with Bipolar II Disorder develops a Manic or Mixed Episode, the diagnosis is changed to Bipolar I disorder.

In **Cyclothymic Disorder,** there are numerous periods of hypomanic symptoms and numerous periods of depressive symptoms that do not meet symptom or duration criteria for a Major Depressive Episode. Bipolar II Disorder is distinguished from Cyclothymic Disorder by the presence of one or more Major Depressive Episodes. If a Major Depressive Episode occurs after the first 2 years of Cyclothymic Disorder, the additional diagnosis of Bipolar II Disorder is given.

Bipolar II Disorder must be distinguished from **Psychotic Disorders** (e.g., Schizoaffective Disorder, Schizophrenia, and Delusional Disorder). Schizophrenia, Schizoaffective Disorder, and Delusional Disorder are all characterized by periods of psychotic symptoms that occur in the absence of prominent mood symptoms. Other helpful considerations include the accompanying symptoms, previous course, and family history.

Diagnostic criteria for 296.89 Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes (see p. 356).

B. Presence (or history) of at least one Hypomanic Episode (see p. 368).

C. There has never been a Manic Episode (see p. 362) or a Mixed Episode (see p. 365).

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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

Specify current or most recent episode:

Hypomanic: if currently (or most recently) in a Hypomanic Episode (see p. 368)
Depressed: if currently (or most recently) in a Major Depressive Episode (see p. 356)

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 411) **Note:** Fifth-digit codes specified on p. 413 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
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 Hypomanic or Major Depressive Episode, *specify* the clinical status of the Bipolar II Disorder and/or features of the most recent Major Depressive Episode (only if it is the most recent type of mood episode):

In Partial Remission, In Full Remission (see p. 411) **Note:** Fifth-digit codes specified on p. 413 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
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)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) (see p. 425)
With Rapid Cycling (see p. 427)

301.13 Cyclothymic Disorder

Diagnostic Features

The essential feature of Cyclothymic Disorder is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms (see p. 365) and numerous periods of depressive symptoms (see p. 349) (Criterion A). The hypomanic symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a Manic Episode, and the depressive symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a Major Depressive Episode. However, it is not necessary that any of the periods of hypomanic symptoms meet either the duration or symptom threshold criterion for a Hypomanic Episode. During the 2-year period (1 year for children or adolescents), any symptom-free intervals last no longer than 2 months (Criterion B). The diagnosis of Cyclothymic Disorder is made only if the initial 2-year period of cyclothymic symptoms is free of Major Depressive, Manic, and Mixed Episodes (Criterion C). After the initial 2 years of the Cyclothymic Disorder, Manic or Mixed Episodes may be superimposed on the Cyclothymic Disorder, in which case both Cyclothymic Disorder and Bipolar I Disorder are diagnosed. Similarly, after the initial 2 years of Cyclothymic Disorder, Major Depressive Episodes may be superimposed on the Cyclothymic Disorder, in which case both Cyclothymic Disorder and Bipolar II Disorder are diagnosed. The diagnosis is not made if the pattern of mood swings is better accounted for by Schizoaffective Disorder or is superimposed on a Psychotic Disorder, such as Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified (Criterion D), in which case the mood symptoms are considered to be associated features of the Psychotic Disorder. The mood disturbance must also not be due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) (Criterion E). Although some people may function particularly well during some of the periods of hypomania, overall there must be clinically significant distress or impairment in social, occupational, or other important areas of functioning as a result of the mood disturbance (Criterion F). The impairment may develop as a result of prolonged periods of cyclical, often unpredictable mood changes (e.g., the person may be regarded as temperamental, moody, unpredictable, inconsistent, or unreliable).

Associated Features and Disorders

Associated descriptive features and mental disorders. Substance-Related Disorders and Sleep Disorders (i.e., difficulties in initiating and maintaining sleep) may be present.

Specific Age and Gender Features

Cyclothymic Disorder often begins early in life and is sometimes considered to reflect a temperamental predisposition to other Mood Disorders (especially Bipolar Disorders). In community samples, Cyclothymic Disorder is apparently equally common

in men and in women. In clinical settings, women with Cyclothymic Disorder may be more likely to present for treatment than men.

Prevalence

Studies have reported a lifetime prevalence of Cyclothymic Disorder of from 0.4% to 1%. Prevalence in mood disorders clinics may range from 3% to 5%.

Course

Cyclothymic Disorder usually begins in adolescence or early adult life. Onset of Cyclothymic Disorder late in adult life may suggest a Mood Disorder Due to a General Medical Condition such as multiple sclerosis. Cyclothymic Disorder usually has an insidious onset and a chronic course. There is a 15%–50% risk that the person will subsequently develop Bipolar I or II Disorder.

Familial Pattern

Major Depressive Disorder and Bipolar I or II Disorder appear to be more common among first-degree biological relatives of persons with Cyclothymic Disorder than among the general population. There may also be an increased familial risk of Substance-Related Disorders. In addition, Cyclothymic Disorder may be more common in the first-degree biological relatives of individuals with Bipolar I Disorder.

Differential Diagnosis

Cyclothymic 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, With Mixed Features, when the mood disturbance is judged to be the direct physiological consequence of a specific, usually chronic general medical condition (e.g., hyperthyroidism) (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., Cyclothymic Disorder) and the general medical condition is recorded on Axis III. This would be the case, for example, if the mood symptoms are considered to be the psychological consequence of having a chronic general medical condition or if there is no etiological relationship between the mood symptoms and the general medical condition.

A **Substance-Induced Mood Disorder** is distinguished from Cyclothymic Disorder by the fact that a substance (especially stimulants) is judged to be etiologically related to the mood disturbance (see p. 405). The frequent mood swings that are suggestive of Cyclothymic Disorder usually dissipate following cessation of drug use.

Bipolar I Disorder, With Rapid Cycling, and **Bipolar II Disorder, With Rapid Cycling,** both may resemble Cyclothymic Disorder by virtue of the frequent marked shifts in mood. By definition, the mood states in Cyclothymic Disorder do not meet the full criteria for a Major Depressive, Manic, or Mixed Episode, whereas the speci-

fier With Rapid Cycling requires that full mood episodes be present. If a Major Depressive, Manic, or Mixed Episode occurs during the course of an established Cyclothymic Disorder, the diagnosis of either Bipolar I Disorder (for a Manic or Mixed Episode) or Bipolar II Disorder (for a Major Depressive Episode) is given along with the diagnosis of Cyclothymic Disorder.

Borderline Personality Disorder is associated with marked shifts in mood that may suggest Cyclothymic Disorder. If the criteria are met for each disorder, both Borderline Personality Disorder and Cyclothymic Disorder may be diagnosed.

Diagnostic criteria for 301.13 Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms (see p. 368) and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode. **Note:** In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No Major Depressive Episode (p. 356), Manic Episode (p. 362), or Mixed Episode (see p. 365) has been present during the first 2 years of the disturbance.

Note: After the initial 2 years (1 year in children and adolescents) of Cyclothymic Disorder, there may be superimposed Manic or Mixed Episodes (in which case both Bipolar I Disorder and Cyclothymic Disorder may be diagnosed) or Major Depressive Episodes (in which case both Bipolar II Disorder and Cyclothymic Disorder may be diagnosed).

D. The symptoms in Criterion A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

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

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

296.80 Bipolar Disorder Not Otherwise Specified

The Bipolar Disorder Not Otherwise Specified category includes disorders with bipolar features that do not meet criteria for any specific Bipolar Disorder. Examples include

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that meet symptom threshold criteria but not minimal duration criteria for Manic, Hypomanic, or Major Depressive Episodes
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms
3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder Not Otherwise Specified

4. Hypomanic Episodes, along with chronic depressive symptoms, that are too infrequent to qualify for a diagnosis of Cyclothymic Disorder
5. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

Other Mood Disorders

293.83 Mood Disorder Due to a General Medical Condition

Diagnostic Features

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve depressed mood; markedly diminished interest or pleasure; or elevated, expansive, or irritable mood (Criterion A). Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met; the predominant symptom type may be indicated by using one of the following subtypes: With Depressive Features, With Major Depressive–Like Episode, With Manic Features, or With Mixed Features. There must be evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition (Criterion B). The mood disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Depressed Mood that occurs in response to the psychosocial stress of having the general medical condition) (Criterion C). The diagnosis is also not made if the mood disturbance occurs only during the course of a delirium (Criterion D). The mood disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). In some cases, the individual may still be able to function, but only with markedly increased effort.

In determining whether the mood 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 mood 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 mood 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 mood disturbance. A second consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at

onset or course or absence of family history). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of mood 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 Mood Disorder, a Substance-Induced Mood Disorder, or other primary mental disorders (e.g., Adjustment Disorder). This determination is explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 181).

In contrast to Major Depressive Disorder, Mood Disorder Due to a General Medical Condition, With Depressive Features, appears to be nearly equally distributed by gender. Mood Disorder Due to a General Medical Condition increases the risk of attempted and completed suicide. Rates of suicide are variable depending on the particular general medical condition, with chronic, incurable, and painful conditions (e.g., malignancy, spinal cord injury, peptic ulcer disease, Huntington's disease, acquired immunodeficiency syndrome [AIDS], end-stage renal disease, head injury) carrying the greatest risk for suicide.

Subtypes

One of the following subtypes may be used to indicate which of the following symptom presentations predominates:

With Depressive Features. This subtype is used if the predominant mood is depressed, but the full criteria for a Major Depressive Episode are not met.

With Major Depressive–Like Episode. This subtype is used if the full criteria (except Criterion D) for a Major Depressive Episode (see p. 356) are met.

With Manic Features. This subtype is used if the predominant mood is elevated, euphoric, or irritable.

With Mixed Features. This subtype is used if the symptoms of both mania and depression are present but neither predominates.

Recording Procedures

In recording the diagnosis of Mood Disorder Due to a General Medical Condition, the clinician should note both the specific phenomenology of the disturbance, including the appropriate subtype, and the identified general medical condition judged to be causing the disturbance on Axis I (e.g., 293.83 Mood Disorder Due to Thyrotoxicosis, With Manic Features). 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 selected ICD-9-CM diagnostic codes for general medical conditions.)

A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given if the depressive symptoms develop exclusively during the course of Vascular Dementia. In this case, the depressive symptoms are indicated by specifying the subtype With Depressed Mood (i.e., 290.43 Vascular Dementia, With Depressed Mood).

Associated General Medical Conditions

A variety of general medical conditions may cause mood symptoms. These conditions include degenerative neurological conditions (e.g., Parkinson's disease, Huntington's disease), cerebrovascular disease (e.g., stroke), metabolic conditions (e.g., vitamin B_{12} deficiency), endocrine conditions (e.g., hyper- and hypothyroidism, hyper- and hypoparathyroidism, hyper- and hypoadrenocorticism), autoimmune conditions (e.g., systemic lupus erythematosus), viral or other infections (e.g., hepatitis, mononucleosis, human immunodeficiency virus [HIV]), and certain cancers (e.g., carcinoma of the pancreas). The associated physical examination findings, laboratory findings, and patterns of prevalence or onset reflect the etiological general medical condition.

Prevalence

Prevalence estimates for Mood Disorder Due to a General Medical Condition are confined to those presentations with depressive features. It has been observed that 25%–40% of individuals with certain neurological conditions (including Parkinson's disease, Huntington's disease, multiple sclerosis, stroke, and Alzheimer's disease) will develop a marked depressive disturbance at some point during the course of the illness. For general medical conditions without direct central nervous system involvement, rates are far more variable, ranging from more than 60% in Cushing's syndrome to less than 8% in end-stage renal disease.

Differential Diagnosis

A separate diagnosis of Mood Disorder Due to a General Medical Condition is not given if the mood disturbance occurs exclusively during the course of a **delirium.** In contrast, a diagnosis of Mood Disorder Due to a General Medical Condition may be given in addition to a diagnosis of **dementia** if the mood symptoms are a direct etiological consequence of the pathological process causing the dementia and if the mood symptoms are a prominent part of the clinical presentation (e.g., Mood Disorder Due to Alzheimer's Disease). Because of ICD-9-CM coding requirements, an exception to this is when depressive symptoms occur exclusively during the course of **Vascular Dementia.** In this case, only a diagnosis of Vascular Dementia with the subtype With Depressed Mood is given; a separate diagnosis of Mood Disorder Due to a General Medical Condition is not made. If the presentation includes a mix of different types of symptoms (e.g., mood and anxiety), the specific mental disorder due to a general medical condition depends on which symptoms 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, a **Substance-Induced Mood 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 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 med-

ical condition and substance use, both diagnoses (i.e., Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder) are given.

Mood Disorder Due to a General Medical Condition must be distinguished from **Major Depressive Disorder, Bipolar I Disorder, Bipolar II Disorder,** and **Adjustment Disorder With Depressed Mood** (e.g., a maladaptive response to the stress of having a general medical condition). In Major Depressive, Bipolar, and Adjustment Disorders, no specific and direct causative physiological mechanisms associated with a general medical condition can be demonstrated. It is often difficult to determine whether certain symptoms (e.g., weight loss, insomnia, fatigue) represent a mood disturbance or are a direct manifestation of a general medical condition (e.g., cancer, stroke, myocardial infarction, diabetes). Such symptoms count toward a diagnosis of a Major Depressive Episode except in cases where they are clearly and fully accounted for by a general medical condition. If the clinician cannot determine whether the mood disturbance is primary, substance induced, or due to a general medical condition, **Mood Disorder Not Otherwise Specified** may be diagnosed.

Diagnostic criteria for 293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition]*

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:

   (1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities

   (2) elevated, expansive, or irritable mood

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 (e.g., Adjustment Disorder With Depressed Mood in response to the stress of having a general medical condition).

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

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

Specify type:

With Depressive Features: if the predominant mood is depressed but the full criteria are not met for a Major Depressive Episode

With Major Depressive–Like Episode: if the full criteria are met (except Criterion D) for a Major Depressive Episode (see p. 356)

With Manic Features: if the predominant mood is elevated, euphoric, or irritable

With Mixed Features: if the symptoms of both mania and depression are present but neither predominates

Diagnostic criteria for 293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition] (continued)*

Coding note: Include the name of the general medical condition on Axis I, e.g., 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features; also code the general medical condition on Axis III (see Appendix G for codes).

Coding note: If depressive symptoms occur as part of a preexisting Vascular Dementia, indicate the depressive symptoms by coding the appropriate subtype, i.e., 290.43 Vascular Dementia, With Depressed Mood.

Substance-Induced Mood Disorder

Diagnostic Features

The essential feature of Substance-Induced Mood Disorder is a prominent and persistent disturbance in mood (Criterion A) that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, other somatic treatment for depression, or toxin exposure) (Criterion B). Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood. Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met. The predominant symptom type may be indicated by using one of the following subtypes: With Depressive Features, With Manic Features, With Mixed Features. The disturbance must not be better accounted for by a Mood Disorder that is not substance induced (Criterion C). The diagnosis is not made if the mood disturbance occurs only during the course of a delirium (Criterion D). The symptoms must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion E). In some cases, the individual may still be able to function, but only with markedly increased effort. This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the mood symptoms are sufficiently severe to warrant independent clinical attention.

A Substance-Induced Mood Disorder is distinguished from a primary Mood 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 Mood Disorders arise only in association with intoxication or withdrawal states, whereas primary Mood Disorders may precede the onset of substance use or may occur during times of sustained abstinence. Because the withdrawal state for some substances can be relatively protracted, mood symptoms can last in an intense form for up to 4 weeks after the cessation of substance use. Another consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at onset or course). For ex-

ample, the onset of a Manic Episode after age 45 years may suggest a substance-induced etiology. In contrast, factors that suggest that the mood symptoms are better accounted for by a primary Mood Disorder include persistence of mood 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 mood 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 episodes of Mood Disorder.

Some medications (e.g., stimulants, steroids, L-dopa, antidepressants) or other somatic treatments for depression (e.g., electroconvulsive therapy or light therapy) can induce manic-like mood disturbances. Clinical judgment is essential to determine whether the treatment is truly causal or whether a primary Mood Disorder happened to have its onset while the person was receiving the treatment. For example, manic symptoms that develop in a person while he or she is taking lithium would not be diagnosed as Substance-Induced Mood Disorder because lithium is not likely to induce manic-like episodes. On the other hand, a depressive episode that developed within the first several weeks of beginning alpha-methyldopa (an antihypertensive agent) in a person with no history of Mood Disorder would qualify for the diagnosis of Alpha-Methyldopa–Induced Mood Disorder, With Depressive Features. In some cases, a previously established condition (e.g., Major Depressive Disorder, Recurrent) can recur while the person is coincidentally taking a medication that has the capacity to cause depressive symptoms (e.g., L-dopa, birth-control pills). In such cases, the clinician must make a judgment as to whether the medication is causative in this particular situation. For a more detailed discussion of Substance-Related Disorders, see p. 191.

Subtypes and Specifiers

One of the following subtypes may be used to indicate which of the following symptom presentations predominates:

> **With Depressive Features.** This subtype is used if the predominant mood is depressed.
> **With Manic Features.** This subtype is used if the predominant mood is elevated, euphoric, or irritable.
> **With Mixed Features.** This subtype is used if the symptoms of both mania and depression are present but neither predominates.

The context of the development of the mood symptoms may be indicated by using one of the following specifiers:

> **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 Mood Disorder begins with the specific substance or somatic treatment (e.g., cocaine, amitriptyline, electroconvulsive therapy) that is presumed to be causing the mood 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., amitriptyline) and for other somatic treatments (e.g., electroconvulsive therapy), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code (see Appendix G). The name of the disorder (e.g., Cocaine-Induced Mood Disorder) is followed by the subtype indicating the predominant symptom presentation and the specifier indicating the context in which the symptoms developed (e.g., 292.84 Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal). When more than one substance is judged to play a significant role in the development of mood symptoms, each should be listed separately (e.g., 292.84 Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Withdrawal; 292.84 Light Therapy–Induced Mood Disorder, With Manic Features). If a substance is judged to be the etiological factor but the specific substance or class of substances is unknown, the category 292.84 Unknown Substance–Induced Mood Disorder may be used.

Specific Substances

Mood Disorders can occur in association with **intoxication** with the following classes of substances: alcohol; amphetamine and related substances; cocaine; hallucinogens; inhalants; opioids; phencyclidine and related substances; sedatives, hypnotics, and anxiolytics; and other or unknown substances. Mood Disorders can occur in association with **withdrawal** from the following classes of substances: alcohol; amphetamine and related substances; cocaine; sedatives, hypnotics, and anxiolytics; and other or unknown substances.

Some of the medications reported to evoke mood symptoms include anesthetics, analgesics, anticholinergics, anticonvulsants, antihypertensives, antiparkinsonian medications, antiulcer medications, cardiac medications, oral contraceptives, psychotropic medications (e.g., antidepressants, benzodiazepines, antipsychotics, disulfiram), muscle relaxants, steroids, and sulfonamides. Some medications have an especially high likelihood of producing depressive features (e.g., high doses of reserpine, corticosteroids, anabolic steroids). Note that this is not an exhaustive list of possible medications and that many medications may occasionally produce an idiosyncratic depressive reaction. Heavy metals and toxins (e.g., volatile substances such as gasoline and paint, organophosphate insecticides, nerve gases, carbon monoxide, carbon dioxide) may also cause mood symptoms.

Differential Diagnosis

Mood symptoms occur commonly in **Substance Intoxication** and **Substance Withdrawal,** and the diagnosis of the substance-specific intoxication or substance-specific withdrawal will usually suffice to categorize the symptom presentation. A diagnosis

of Substance-Induced Mood Disorder should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are judged to be in excess of those usually associated with the intoxication or withdrawal syndrome and when the mood symptoms are sufficiently severe to warrant independent clinical attention. For example, dysphoric mood is a characteristic feature of Cocaine Withdrawal. Cocaine-Induced Mood Disorder should be diagnosed instead of Cocaine Withdrawal only if the mood disturbance is substantially more intense than what is usually encountered with Cocaine Withdrawal and is sufficiently severe to be a separate focus of attention and treatment.

If substance-induced mood symptoms occur exclusively during the course of a **delirium,** the mood symptoms are considered to be an associated feature of the delirium and are not diagnosed separately. In **substance-induced presentations that contain a mix of different types of symptoms** (e.g., mood, psychotic, and anxiety symptoms), the specific type of Substance-Induced Disorder to be diagnosed depends on which type of symptoms predominates in the clinical presentation.

A Substance-Induced Mood Disorder is distinguished from a **primary Mood Disorder** by the fact that a substance is judged to be etiologically related to the symptoms (p. 405).

A Substance-Induced Mood Disorder due to a prescribed treatment for a mental disorder or general medical condition must have its onset while the person is receiving the medication (e.g., antihypertensive medication) or during withdrawal, if there is a withdrawal syndrome associated with the medication. Once the treatment is discontinued, the mood symptoms will usually remit within days to several week (depending on the half-life of the substance and the presence of a withdrawal syr drome). If symptoms persist beyond 4 weeks, other causes for the mood symptom should be considered.

Because individuals with general medical conditions often take medications fc those conditions, the clinician must consider the possibility that the mood symptom are caused by the physiological consequences of the general medical condition rathe than the medication, in which case **Mood 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., Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder) may be given. When there is insufficient evidence to determine whether the mood 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), **Depressive Disorder Not Otherwise Specified** or **Bipolar Disorder Not Otherwise Specified** would be indicated.

Diagnostic criteria for Substance-Induced Mood Disorder

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:

   (1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities
   (2) elevated, expansive, or irritable mood

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 Mood Disorder that is not substance induced. Evidence that the symptoms are better accounted for by a Mood 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 Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).

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

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

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood 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.

Code [Specific Substance]–Induced Mood Disorder:

(291.89 Alcohol; 292.84 Amphetamine [or Amphetamine-Like Substance]; 292.84 Cocaine; 292.84 Hallucinogen; 292.84 Inhalant; 292.84 Opioid; 292.84 Phencyclidine [or Phencyclidine-Like Substance]; 292.84 Sedative, Hypnotic, or Anxiolytic; 292.84 Other [or Unknown] Substance)

Specify type:

With Depressive Features: if the predominant mood is depressed
With Manic Features: if the predominant mood is elevated, euphoric, or irritable
With Mixed Features: if symptoms of both mania and depression are present and neither predominates

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

With Onset During Intoxication: if the 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

296.90 Mood Disorder Not Otherwise Specified

This category includes 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).

Specifiers Describing Current or Most Recent Episode

A number of specifiers for Mood Disorders are provided to increase diagnostic specificity and create more homogeneous subgroups, assist in treatment selection, and improve the prediction of prognosis. The Severity/Psychotic/Remission specifiers describe the current clinical status of the Mood Disorder. The following specifiers describe symptom or course features of the current mood episode (or the most recent mood episode if criteria are not currently met for any episode): Chronic, With Catatonic Features, With Melancholic Features, With Atypical Features, and With Postpartum Onset. 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. Table 1 indicates which episode specifiers apply to each Mood Disorder (see p. 411).

Table 1. Episode specifiers that apply to Mood Disorders

	Severity/ Psychotic/ Remission	Chronic	With Catatonic Features	With Melancholic Features	With Atypical Features	With Post-partum Onset
Major Depressive Disorder, Single Episode	X	X	X	X	X	X
Major Depressive Disorder, Recurrent	X	X	X	X	X	X
Dysthymic Disorder					X	
Bipolar I Disorder, Single Manic Episode	X		X			X
Bipolar I Disorder, Most Recent Episode Hypomanic						
Bipolar I Disorder, Most Recent Episode Manic	X		X			X
Bipolar I Disorder, Most Recent Episode Mixed	X		X			X
Bipolar I Disorder, Most Recent Episode Depressed	X	X	X	X	X	X
Bipolar I Disorder, Most Recent Episode Unspecified						
Bipolar II Disorder, Hypomanic						
Bipolar II Disorder, Depressed	X	X	X	X	X	X
Cyclothymic Disorder						

Severity/Psychotic/Remission Specifiers for Major Depressive Episode

In Major Depressive Disorder, these specifiers indicate either the severity of the current Major Depressive Episode or the level of remission if full criteria are no longer met. In Bipolar I and Bipolar II Disorder, these specifiers indicate either the severity of the current Major Depressive Episode or the level of remission if the most recent episode was a Major Depressive Episode. If criteria are currently met for the Major Depressive Episode, it can be classified as Mild, Moderate, Severe Without Psychotic

Features, or Severe With Psychotic Features. If the criteria are no longer met, the specifier indicates whether the most recent Major Depressive Episode is in partial or full remission. For Major Depressive Disorder and most of the Bipolar I Disorders, the specifier is reflected in the fifth-digit coding for the disorder.

1—Mild, 2—Moderate, 3—Severe Without Psychotic Features. Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. *Mild* episodes are characterized by the presence of only five or six depressive symptoms and either mild disability or the capacity to function normally but with substantial and unusual effort. Episodes that are *Severe Without Psychotic Features* are characterized by the presence of most of the criteria symptoms and clear-cut, observable disability (e.g., inability to work or care for children). *Moderate* episodes have a severity that is intermediate between mild and severe.

4—Severe With Psychotic Features. This specifier indicates the presence of either delusions or hallucinations (typically auditory) during the current episode. Most commonly, the content of the delusions or hallucinations is consistent with the depressive themes. Such *mood-congruent psychotic features* include delusions of guilt (e.g., of being responsible for illness in a loved one), delusions of deserved punishment (e.g., of being punished because of a moral transgression or some personal inadequacy), nihilistic delusions (e.g., of world or personal destruction), somatic delusions (e.g., of cancer or one's body "rotting away"), or delusions of poverty (e.g., of being bankrupt). Hallucinations, when present, are usually transient and not elaborate and may involve voices that berate the person for shortcomings or sins.

Less commonly, the content of the hallucinations or delusions has no apparent relationship to depressive themes. Such *mood-incongruent psychotic features* include persecutory delusions (without depressive themes that the individual deserves to be persecuted), delusions of thought insertion (i.e., one's thoughts are not one's own), delusions of thought broadcasting (i.e., others can hear one's thoughts), and delusions of control (i.e., one's actions are under outside control). These features are associated with a poorer prognosis. The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features or With Mood-Incongruent Features.

5—In Partial Remission, 6—In Full Remission. Full Remission requires a period of at least 2 months in which there are no significant symptoms of depression. There are two ways for the episode to be In Partial Remission: 1) some symptoms of a Major Depressive Episode are still present, but full criteria are no longer met; or 2) there are no longer any significant symptoms of a Major Depressive Episode, but the period of remission has been less than 2 months. If the Major Depressive Episode has been superimposed on Dysthymic Disorder, the diagnosis of Major Depressive Disorder, In Partial Remission, is not given once the full criteria for a Major Depressive Episode are no longer met; instead, the diagnosis is Dysthymic Disorder and Major Depressive Disorder, Prior History.

Criteria for Severity/Psychotic/Remission Specifiers for current (or most recent) Major Depressive Episode

Note: Code in fifth digit. Mild, Moderate, Severe Without Psychotic Features, and Severe With Psychotic Features can be applied only if the criteria are currently met for a Major Depressive Episode. In Partial Remission and In Full Remission can be applied to the most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode.

.x1—Mild: Few, if any, symptoms in excess of those required to make the diagnosis and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.
.x2—Moderate: Symptoms or functional impairment between "mild" and "severe."
.x3—Severe Without Psychotic Features: Several symptoms in excess of those required to make the diagnosis, **and** symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.
.x4—Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

> **Mood-Congruent Psychotic Features:** Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment.
> **Mood-Incongruent Psychotic Features:** Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included are such symptoms as persecutory delusions (not directly related to depressive themes), thought insertion, thought broadcasting, and delusions of control.

.x5—In Partial Remission: Symptoms of a Major Depressive Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Major Depressive Episode lasting less than 2 months following the end of the Major Depressive Episode. (If the Major Depressive Episode was superimposed on Dysthymic Disorder, the diagnosis of Dysthymic Disorder alone is given once the full criteria for a Major Depressive Episode are no longer met.)
.x6—In Full Remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.
.x0—Unspecified.

Severity/Psychotic/Remission Specifiers for Manic Episode

In Bipolar I Disorder, these specifiers indicate either the severity of the current Manic Episode or the level of remission if the most recent episode was a Manic Episode. If criteria are currently met for the Manic Episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe With Psychotic Features. If the criteria are no longer met for a Manic Episode, the specifier indicates whether the most recent Manic Episode is in partial or full remission. These specifiers are reflected in the fifth-digit coding for the disorder.

1—Mild, 2—Moderate, 3—Severe Without Psychotic Features. Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, the degree of functional disability, and the need for supervision. *Mild* episodes are characterized by the presence of only three or four manic symptoms. *Moderate* episodes are characterized by an extreme increase in activity or impairment in judgment. Episodes that are *Severe Without Psychotic Features* are characterized by the need for almost continual supervision to protect the individual from harm to self or others.

4—Severe With Psychotic Features. This specifier indicates the presence of either delusions or hallucinations (typically auditory) during the current episode. Most commonly, the content of the delusions or hallucinations is consistent with the manic themes, that is, they are *mood-congruent psychotic features.* For example, God's voice may be heard explaining that the person has a special mission. Persecutory delusions may be based on the idea that the person is being persecuted because of some special relationship or attribute.

Less commonly, the content of the hallucinations or delusions has no apparent relationship to manic themes, that is, they are *mood-incongruent psychotic features.* These may include persecutory delusions (not directly related to grandiose themes), delusions of thought insertion (i.e., one's thoughts are not one's own), delusions of thought broadcasting (i.e., others can hear one's thoughts), and delusions of control (i.e., one's actions are under outside control). The presence of these features may be associated with a poorer prognosis. The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features or With Mood-Incongruent Features.

5—In Partial Remission, 6—In Full Remission. Full Remission requires a period of at least 2 months in which there are no significant symptoms of mania. There are two ways for the episode to be In Partial Remission: 1) symptoms of a Manic Episode are still present, but full criteria are no longer met; or 2) there are no longer any significant symptoms of a Manic Episode, but the period of remission has been less than 2 months.

Criteria for Severity/Psychotic/Remission Specifiers for current (or most recent) Manic Episode

Note: Code in fifth digit. Mild, Moderate, Severe Without Psychotic Features, and Severe With Psychotic Features can be applied only if the criteria are currently met for a Manic Episode. In Partial Remission and In Full Remission can be applied to a Manic Episode in Bipolar I Disorder only if it is the most recent type of mood episode.

.x1—Mild: Minimum symptom criteria are met for a Manic Episode.
.x2—Moderate: Extreme increase in activity or impairment in judgment.
.x3—Severe Without Psychotic Features: Almost continual supervision required to prevent physical harm to self or others.
.x4—Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

> **Mood-Congruent Psychotic Features:** Delusions or hallucinations whose content is entirely consistent with the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.
> **Mood-Incongruent Psychotic Features:** Delusions or hallucinations whose content does not involve typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person. Included are such symptoms as persecutory delusions (not directly related to grandiose ideas or themes), thought insertion, and delusions of being controlled.

.x5—In Partial Remission: Symptoms of a Manic Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Manic Episode lasting less than 2 months following the end of the Manic Episode.
.x6—In Full Remission: During the past 2 months no significant signs or symptoms of the disturbance were present.
.x0—Unspecified.

Severity/Psychotic/Remission Specifiers for Mixed Episode

In Bipolar I Disorder, these specifiers indicate either the severity of the current Mixed Episode or the level of remission if the most recent episode was a Mixed Episode. If criteria are currently met for the Mixed Episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe With Psychotic Features. If the criteria are no longer met for a Mixed Episode, the specifier indicates whether the most recent Mixed Episode is in partial or full remission. These specifiers are reflected in the fifth-digit coding for the disorder.

1—Mild, 2—Moderate, 3—Severe Without Psychotic Features. Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, the degree of functional disability, and the need for supervision. *Mild* episodes are characterized by the presence of only three or four manic symp-

toms and five or six depressive symptoms. *Moderate* episodes are characterized by an extreme increase in activity or impairment in judgment. Episodes that are *Severe Without Psychotic Features* are characterized by the need for almost continual supervision to protect the individual from harm to self or others.

4—Severe With Psychotic Features. This specifier indicates the presence of either delusions or hallucinations (typically auditory) during the current episode. Most commonly, the content of the delusions or hallucinations is consistent with either the manic or depressive themes, that is, they are *mood-congruent psychotic features*. For example, God's voice may be heard explaining that the person has a special mission. Persecutory delusions may be based on the idea that the person is being persecuted because of being especially deserving of punishment or having some special relationship or attribute.

Less commonly, the content of the hallucinations or delusions has no apparent relationship to either manic or depressive themes, that is, they are *mood-incongruent psychotic features*. These may include delusions of thought insertion (i.e., one's thoughts are not one's own), delusions of thought broadcasting (i.e., others can hear one's thoughts), and delusions of control (i.e., one's actions are under outside control). These features are associated with a poorer prognosis. The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features or With Mood-Incongruent Features.

5—In Partial Remission, 6—In Full Remission. Full Remission requires a period of at least 2 months in which there are no significant symptoms of mania or depression. There are two ways for the episode to be In Partial Remission: 1) symptoms of a Mixed Episode are still present, but full criteria are no longer met; or 2) there are no longer any significant symptoms of a Mixed Episode, but the period of remission has been less than 2 months.

Criteria for Severity/Psychotic/Remission Specifiers for current (or most recent) Mixed Episode

Note: Code in fifth digit. Mild, Moderate, Severe Without Psychotic Features, and Severe With Psychotic Features can be applied only if the criteria are currently met for a Mixed Episode. In Partial Remission and In Full Remission can be applied to a Mixed Episode in Bipolar I Disorder only if it is the most recent type of mood episode.

.x1—Mild: No more than minimum symptom criteria are met for both a Manic Episode and a Major Depressive Episode.
.x2—Moderate: Symptoms or functional impairment between "mild" and "severe."
.x3—Severe Without Psychotic Features: Almost continual supervision required to prevent physical harm to self or others.
.x4—Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Criteria for Severity/Psychotic/Remission Specifiers for current (or most recent) Mixed Episode *(continued)*

Mood-Congruent Psychotic Features: Delusions or hallucinations whose content is entirely consistent with the typical manic or depressive themes.
Mood-Incongruent Psychotic Features: Delusions or hallucinations whose content does not involve typical manic or depressive themes. Included are such symptoms as persecutory delusions (not directly related to grandiose or depressive themes), thought insertion, and delusions of being controlled.

.x5—In Partial Remission: Symptoms of a Mixed Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Mixed Episode lasting less than 2 months following the end of the Mixed Episode.
.x6—In Full Remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.
.x0—Unspecified.

Chronic Specifier for a Major Depressive Episode

This specifier indicates the chronic nature of a Major Depressive Episode (i.e., that full criteria for a Major Depressive Episode have been continuously met for at least 2 years). This specifier applies to the current (or, if the full criteria are not currently met for a Major Depressive Episode, to the most recent) Major Depressive Episode in Major Depressive Disorder and to the current (or most recent) Major Depressive Episode in Bipolar I or Bipolar II Disorder only if it is the most recent type of mood episode.

Criteria for Chronic Specifier

Specify if:

Chronic (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode)

Full criteria for a Major Depressive Episode have been met continuously for at least the past 2 years.

Catatonic Features Specifier

The specifier With Catatonic Features can be applied to the current Major Depressive, Manic, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder. If full criteria are no longer met for a mood episode, the specifier applies to the most recent mood episode. The specifier With Catatonic Features is appropriate when the clinical picture is characterized by 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 assumption of inappropriate or bizarre postures or by prominent grimacing. Echolalia (the pathological, parrotlike, and apparently senseless repetition of a word or phrase just spoken by another person) and echopraxia (the repetitive imitation of the movements of another person) are often present. Additional features may 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 harm to others. Potential consequences include malnutrition, exhaustion, hyperpyrexia, or self-inflicted injury.

Catatonic states have been found to occur in 5%–9% of inpatients. Among inpatients with catatonia, 25%–50% of cases occur in association with Mood Disorders, 10%–15% of cases occur in association with Schizophrenia (see Schizophrenia, Catatonic Type, p. 315), and the remainder occur in association with other mental disorders (e.g., Obsessive-Compulsive Disorder, Personality Disorders, and Dissociative Disorders). It is important to note that catatonia can also occur in a wide variety of general medical conditions including, but not limited to, those due to infectious, metabolic, neurological conditions (see **Catatonic Disorder Due to a General Medical Condition,** p. 185), or can be due to a side effect of a medication (e.g., a **Medication-Induced Movement Disorder,** see p. 791). Because of the seriousness of the complications, particular attention should be paid to the possibility that the catatonia is due to **Neuroleptic Malignant Syndrome** (p. 795).

Criteria for Catatonic Features Specifier

Specify if:

With Catatonic Features (can be applied to the current or most recent Major Depressive Episode, Manic Episode, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder)

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

Melancholic Features Specifier

The specifier With Melancholic Features can be applied to the current (or, if the full criteria are not currently met for a Major Depressive Episode, to the most recent) Major Depressive Episode in Major Depressive Disorder and to the current (or most recent) Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode. The essential feature of a Major Depressive Episode, With Melancholic Features, is loss of interest or pleasure in all, or almost all, activities or a lack of reactivity to usually pleasurable stimuli. The individual's depressed mood does not improve, even temporarily, when something good happens (Criterion A). In addition, at least three of the following symptoms are present: a distinct quality of the depressed mood, depression that is regularly worse in the morning, early morning awakening, psychomotor retardation or agitation, significant anorexia or weight loss, or excessive or inappropriate guilt (Criterion B).

The specifier With Melancholic Features is applied if these features are present at the nadir of the episode. There is a near-complete absence of the capacity for pleasure, not merely a diminution. A guideline for evaluating the lack of reactivity of mood is that, even for very desired events, the depressed mood does not brighten at all or brightens only partially (e.g., up to 20%–40% of normal for only minutes at a time). The distinct quality of mood that is characteristic of the With Melancholic Features specifier is experienced by individuals as qualitatively different from the sadness experienced during bereavement or a nonmelancholic depressive episode. This may be elicited by asking the person to compare the quality of the current depressed mood with the mood experienced after the death of a loved one. A depressed mood that is described as merely more severe, longer-lasting, or present without a reason is not considered distinct in quality. Psychomotor changes are nearly always present and are observable by others. Individuals with melancholic features are less likely to have a premorbid Personality Disorder, to have a clear precipitant to the episode, and to respond to a trial of placebo medication. One consequence of a lower probability of response to placebo is a greater need for active antidepressant treatment.

These features exhibit only a modest tendency to repeat across episodes in the same individual. They are more frequent in inpatients, as opposed to outpatients, and are less likely to occur in milder than in more severe Major Depressive Episodes and are more likely to occur in those with psychotic features. Melancholic features are more frequently associated with laboratory findings of dexamethasone nonsuppression; elevated cortisol concentrations in plasma, urine, and saliva; alterations of sleep EEG profiles; abnormal tyramine challenge test; and an abnormal asymmetry on dichotic listening tasks.

Criteria for Melancholic Features Specifier

Specify if:

With Melancholic Features (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or Bipolar II Disorder only if it is the most recent type of mood episode)

A. Either of the following, occurring during the most severe period of the current episode:

(1) loss of pleasure in all, or almost all, activities
(2) lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens)

B. Three (or more) of the following:

(1) distinct quality of depressed mood (i.e., the depressed mood is experienced as distinctly different from the kind of feeling experienced after the death of a loved one)
(2) depression regularly worse in the morning
(3) early morning awakening (at least 2 hours before usual time of awakening)
(4) marked psychomotor retardation or agitation
(5) significant anorexia or weight loss
(6) excessive or inappropriate guilt

Atypical Features Specifier

The specifier With Atypical Features can be applied to the current (or, if the full criteria are not currently met for a Major Depressive Episode, to the most recent) Major Depressive Episode in Major Depressive Disorder and to the current (or most recent) Major Depressive Episode in Bipolar I or Bipolar II Disorder only if it is the most recent type of mood episode, or to Dysthymic Disorder. "Atypical depression" has historical significance (i.e., atypical in contradistinction to the more classical "endogenous" presentations of depression) and does not connote an uncommon or unusual clinical presentation as the term might imply. The essential features are mood reactivity (Criterion A) and the presence of at least two of the following features (Criterion B): increased appetite or weight gain, hypersomnia, leaden paralysis, and a long-standing pattern of extreme sensitivity to perceived interpersonal rejection. These features predominate during the most recent 2-week period (or the most recent 2-year period for Dysthymic Disorder). The specifier With Atypical Features is not given if the criteria for With Melancholic Features or With Catatonic Features have been met during the same Major Depressive Episode. When used to describe the most recent Major Depressive Episode (as opposed to a current episode), the specifier applies if the features predominate during any 2-week period.

Mood reactivity is the capacity to be cheered up when presented with positive events (e.g., a visit from children, compliments from others). Mood may become euthymic (not sad) even for extended periods of time if the external circumstances remain favorable. Increased appetite may be manifested by an obvious increase in food intake or by weight gain. Hypersomnia may include either an extended period of nighttime sleep or daytime napping that totals at least 10 hours of sleep per day (or at least 2 hours more than when not depressed). Leaden paralysis is defined as feeling heavy, leaden, or weighted down, usually in the arms or legs; this is generally present for at least an hour a day but often lasts for many hours at a time. Unlike the other atypical features, pathological sensitivity to perceived interpersonal rejection is a trait that has an early onset and persists throughout most of adult life. Rejection sensitivity occurs both when the person is and is not depressed, though it may be exacerbated during depressive periods. The problems that result from rejection sensitivity must be significant enough to result in functional impairment. There may be stormy relationships with frequent disruptions and an inability to sustain a longer-lasting relationship. The individual's reaction to rebuff or criticism may be manifested by leaving work early, using substances excessively, or displaying other clinically significant maladaptive behavioral responses. There may also be avoidance of relationships due to the fear of interpersonal rejection. Being occasionally touchy or overemotional does not qualify as a manifestation of interpersonal rejection sensitivity. Personality Disorders (e.g., Avoidant Personality Disorder) and Anxiety Disorders (e.g., Separation Anxiety Disorder, Specific Phobia, or Social Phobia) may be more common in those with atypical features. The laboratory findings associated with a Major Depressive Episode With Melancholic Features are generally not present in association with an episode with atypical features.

Atypical features are two to three times more common in women. Individuals with atypical features report an earlier age at onset of their depressive episodes (e.g., while in high school) and frequently have a more chronic, less episodic course, with only partial interepisode recovery. Younger individuals may be more likely to have episodes with atypical features, whereas older individuals may more often have episodes with melancholic features. Episodes with atypical features are more common in Bipolar I Disorder, Bipolar II Disorder, and in Major Depressive Disorder, Recurrent, occurring in a seasonal pattern. Depressive episodes with Atypical Features are more likely to respond to treatment with monoamine oxidase inhibitors than with tricyclic antidepressants. The predictive value of Atypical Features is less clear with newer treatments, such as selective serotonin reuptake inhibitors or interpersonal or cognitive psychotherapies.

Criteria for Atypical Features Specifier

Specify if:

With Atypical Features (can be applied when these features predominate during the most recent 2 weeks of a current Major Depressive Episode in Major Depressive Disorder or in Bipolar I or Bipolar II Disorder when a current Major Depressive Episode is the most recent type of mood episode, or when these features predominate during the most recent 2 years of Dysthymic Disorder; if the Major Depressive Episode is not current, it applies if the feature predominates during any 2-week period)

A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events)

B. Two (or more) of the following features:

(1) significant weight gain or increase in appetite
(2) hypersomnia
(3) leaden paralysis (i.e., heavy, leaden feelings in arms or legs)
(4) long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment

C. Criteria are not met for With Melancholic Features or With Catatonic Features during the same episode.

Postpartum Onset Specifier

The specifier With Postpartum Onset can be applied to the current (or, if the full criteria are not currently met for a Major Depressive, Manic, or Mixed Episode, to the most recent) Major Depressive, Manic, or Mixed Episode of Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder or to Brief Psychotic Disorder (p. 329) if onset is within 4 weeks after childbirth. The symptoms of the postpartum-onset Major Depressive, Manic, or Mixed Episode do not differ from the symptoms in nonpostpartum mood episodes. Symptoms that are common in postpartum-onset episodes, though not specific to postpartum onset, include fluctuations in mood, mood lability, and preoccupation with infant well-being, the intensity of which may range from overconcern to frank delusions. The presence of severe ruminations or delusional thoughts about the infant is associated with a significantly increased risk of harm to the infant.

Postpartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but it can also occur in severe postpartum mood episodes without such specific delusions or hallucinations. Postpartum mood (Major Depressive, Manic, or Mixed) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women. The risk of post-

partum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of a Mood Disorder (especially Bipolar I Disorder). Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50%. There is also some evidence of increased risk of postpartum psychotic mood episodes among women without a history of Mood Disorders with a family history of Bipolar Disorders. Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a decreased level of awareness or attention.

Women with postpartum Major Depressive Episodes often have severe anxiety and even Panic Attacks. Maternal attitudes toward the infant are highly variable but can include disinterest, fearfulness of being alone with the infant, or overintrusiveness that inhibits adequate infant rest. It is important to distinguish postpartum mood episodes from the "baby blues," which affect up to 70% of women during the 10 days postpartum, are transient, and do not impair functioning. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the "baby blues," increase the risk for a postpartum Major Depressive Episode. A past personal history of nonpostpartum Mood Disorder and a family history of Mood Disorders also increase the risk for the development of a postpartum Mood Disorder. The risk factors, recurrence rates, and symptoms of postpartum-onset Mood Episodes are similar to those of nonpostpartum Mood Episodes. However, the postpartum period is unique with respect to the degree of neuroendocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum Mood Disorder on subsequent family planning.

Criteria for Postpartum Onset Specifier

Specify if:

With Postpartum Onset (can be applied to the current or most recent Major Depressive, Manic, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder; or to Brief Psychotic Disorder)

Onset of episode within 4 weeks postpartum

Specifiers Describing Course of Recurrent Episodes

A number of specifiers for Mood Disorders are provided to increase diagnostic specificity and create more homogeneous subgroups, assist in treatment selection, and improve the prediction of prognosis. Specifiers that describe the course of recurrent episodes include Longitudinal Course Specifiers (With and Without Full Interepisode Recovery), Seasonal Pattern, and Rapid Cycling. These specifiers cannot be coded. Table 2 indicates which course specifiers apply to each Mood Disorder (see p. 424).

Table 2. Course specifiers that apply to Mood Disorders

	With/Without Interepisode Recovery	Seasonal Pattern	Rapid Cycling
Major Depressive Disorder, Single Episode			
Major Depressive Disorder, Recurrent	X	X	
Dysthymic Disorder			
Bipolar I Disorder, Single Manic Episode			
Bipolar I Disorder, Most Recent Episode Hypomanic	X	X	X
Bipolar I Disorder, Most Recent Episode Manic	X	X	X
Bipolar I Disorder, Most Recent Episode Mixed	X	X	X
Bipolar I Disorder, Most Recent Episode Depressed	X	X	X
Bipolar I Disorder, Most Recent Episode Unspecified	X	X	X
Bipolar II Disorder, Hypomanic	X	X	X
Bipolar II Disorder, Depressed	X	X	X
Cyclothymic Disorder			

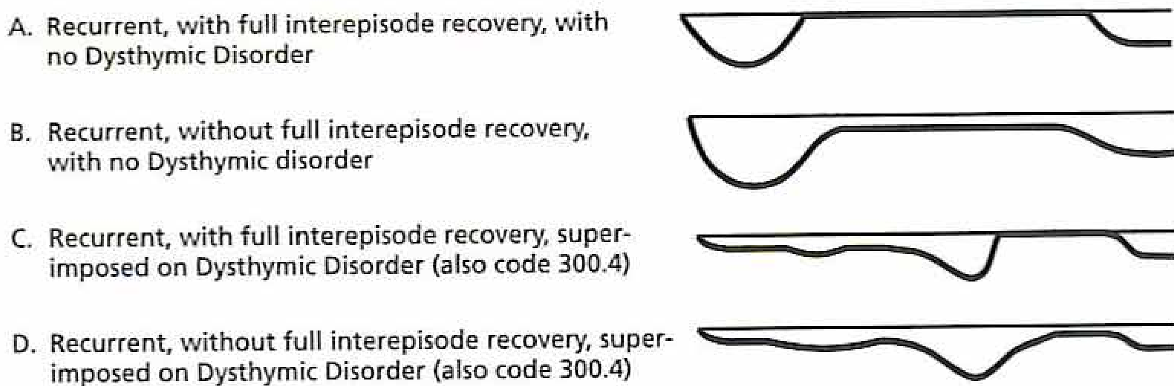
Longitudinal Course Specifiers (With and Without Full Interepisode Recovery)

The specifiers With Full Interepisode Recovery and Without Full Interepisode Recovery are provided to help characterize the course of illness in individuals with Recurrent Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder. These specifiers should be applied to the period of time between the two most recent episodes. The characterization of course is further enhanced by noting the presence of antecedent Dysthymic Disorder.

The four graphs below depict prototypical courses. *A* shows the course of Major Depressive Disorder, Recurrent, in which there is no antecedent Dysthymic Disorder and there is a period of full remission between the episodes. This course pattern predicts the best future prognosis. *B* shows the course of Major Depressive Disorder, Recurrent, in which there is no antecedent Dysthymic Disorder but in which prominent

symptoms persist between the two most recent episodes—that is, no more than partial remission is attained. *C* shows the rare pattern (present in fewer than 3% of individuals with Major Depressive Disorder) of Major Depressive Disorder, Recurrent, with antecedent Dysthymic Disorder but with full interepisode recovery between the two most recent episodes. *D* shows the course of Major Depressive Disorder, Recurrent, in which there is antecedent Dysthymic Disorder and in which there is no period of full remission between the two most recent episodes. This pattern, commonly referred to as "double depression" (see p. 377), is seen in about 20%–25% of individuals with Major Depressive Disorder.

In general, individuals with a history of Without Full Interepisode Recovery have a persistence of that pattern between subsequent episodes. They also appear more likely to have more Major Depressive Episodes than those with full interepisode recovery. Dysthymic Disorder prior to the first episode of Major Depressive Disorder is most likely to be associated with lack of full interepisode recovery subsequently. These specifiers may also be applied to the period of time between the most recent mood episodes in Bipolar I Disorder or Bipolar II Disorder to indicate presence or absence of mood symptoms.



Criteria for Longitudinal Course Specifiers

Specify if (can be applied to Recurrent Major Depressive Disorder or Bipolar I or II Disorder):

With Full Interepisode Recovery: if full remission is attained between the two most recent Mood Episodes

Without Full Interepisode Recovery: if full remission is not attained between the two most recent Mood Episodes

Seasonal Pattern Specifier

The specifier With Seasonal Pattern can be applied to the pattern of Major Depressive Episodes in Bipolar I Disorder, Bipolar II Disorder, or Major Depressive Disorder, Recurrent. The essential feature is the onset and remission of Major Depressive Episodes

at characteristic times of the year. In most cases, the episodes begin in fall or winter and remit in spring. Less commonly, there may be recurrent summer depressive episodes. This pattern of onset and remission of episodes must have occurred during the last 2 years, without any nonseasonal episodes occurring during this period. In addition, the seasonal depressive episodes must substantially outnumber any nonseasonal depressive episodes over the individual's lifetime. This specifier does not apply to those situations in which the pattern is better explained by seasonally linked psychosocial stressors (e.g., seasonal unemployment or school schedule). Major Depressive Episodes that occur in a seasonal pattern are often characterized by prominent anergy, hypersomnia, overeating, weight gain, and a craving for carbohydrates. It is unclear whether a seasonal pattern is more likely in Major Depressive Disorder, Recurrent, or in Bipolar Disorders. However, within the Bipolar Disorders group, a seasonal pattern appears to be more likely in Bipolar II Disorder than in Bipolar I Disorder. In some individuals, the onset of Manic or Hypomanic Episodes may also be linked to a particular season. Bright visible-spectrum light used in treatment may be associated with switches into Manic or Hypomanic Episodes.

The prevalence of winter-type seasonal pattern appears to vary with latitude, age, and sex. Prevalence increases with higher latitudes. Age is also a strong predictor of seasonality, with younger persons at higher risk for winter depressive episodes. Women comprise 60%–90% of persons with seasonal pattern, but it is unclear whether female gender is a specific risk factor over and above the risk associated with recurrent Major Depressive Disorder. Although this specifier applies to seasonal occurrence of full Major Depressive Episodes, some research suggests that a seasonal pattern may also describe the presentation in some individuals with recurrent winter depressive episodes that do not meet criteria for a Major Depressive Episode.

Criteria for Seasonal Pattern Specifier

Specify if:

With Seasonal Pattern (can be applied to the pattern of Major Depressive Episodes in Bipolar I Disorder, Bipolar II Disorder, or Major Depressive Disorder, Recurrent)

A. There has been a regular temporal relationship between the onset of Major Depressive Episodes in Bipolar I or Bipolar II Disorder or Major Depressive Disorder, Recurrent, and a particular time of the year (e.g., regular appearance of the Major Depressive Episode in the fall or winter).

Note: Do not include cases in which there is an obvious effect of seasonal-related psychosocial stressors (e.g., regularly being unemployed every winter).

B. Full remissions (or a change from depression to mania or hypomania) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

C. In the last 2 years, two Major Depressive Episodes have occurred that demonstrate the temporal seasonal relationships defined in Criteria A and B, and no nonseasonal Major Depressive Episodes have occurred during that same period.

D. Seasonal Major Depressive Episodes (as described above) substantially outnumber the nonseasonal Major Depressive Episodes that may have occurred over the individual's lifetime.

Rapid-Cycling Specifier

The specifier With Rapid Cycling can be applied to Bipolar I Disorder or Bipolar II Disorder. The essential feature of a rapid-cycling Bipolar Disorder is the occurrence of four or more mood episodes during the previous 12 months. These episodes can occur in any combination and order. The episodes must meet both the duration and symptom criteria for a Major Depressive, Manic, Mixed, or Hypomanic Episode and must be demarcated by either a period of full remission or by a switch to an episode of the opposite polarity. Manic, Hypomanic, and Mixed Episodes are counted as being on the same pole (e.g., a Manic Episode immediately followed by a Mixed Episode counts as only one episode in considering the specifier With Rapid Cycling). Except for the fact that they occur more frequently, the episodes that occur in a rapid-cycling pattern are no different from those that occur in a non-rapid-cycling pattern. Mood episodes that count toward defining a rapid-cycling pattern exclude those episodes directly caused by a substance (e.g., cocaine, corticosteroids) or a general medical condition.

Rapid cycling occurs in approximately 10%–20% of individuals with Bipolar Disorder seen in Mood Disorders clinics. Whereas in Bipolar Disorder in general the sex ratio is equal, women comprise 70%–90% of individuals with a rapid-cycling pattern. The mood episodes are not linked to any phase of the menstrual cycle and occur in both pre- and postmenopausal women. Rapid cycling may be associated with hypo-

thyroidism, certain neurological conditions (e.g., multiple sclerosis), Mental Retardation, head injury, or antidepressant treatment. Rapid cycling can occur at any time during the course of Bipolar Disorder and may appear and disappear, particularly if it is associated with antidepressant use. There is some evidence that some individuals with rapid cycling have an acceleration of their cycling rate after exposure to antidepressant medication. The development of rapid cycling is associated with a poorer longer-term prognosis.

Criteria for Rapid-Cycling Specifier

Specify if:

With Rapid Cycling (can be applied to Bipolar I Disorder or Bipolar II Disorder)

At least four episodes of a mood disturbance in the previous 12 months that meet criteria for a Major Depressive, Manic, Mixed, or Hypomanic Episode.

Note: Episodes are demarcated either by partial or full remission for at least 2 months or a switch to an episode of opposite polarity (e.g., Major Depressive Episode to Manic Episode).

Anxiety Disorders

The following disorders are contained in this section: Panic Disorder Without Agoraphobia, Panic Disorder With Agoraphobia, Agoraphobia Without History of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Substance-Induced Anxiety Disorder, and Anxiety Disorder Not Otherwise Specified. Because Panic Attacks and Agoraphobia occur in the context of several of these disorders, criteria sets for a Panic Attack and for Agoraphobia are listed separately at the beginning of this section.

A **Panic Attack** is a discrete period in which there is the sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom. During these attacks, symptoms such as shortness of breath, palpitations, chest pain or discomfort, choking or smothering sensations, and fear of "going crazy" or losing control are present.

Agoraphobia is anxiety about, or avoidance of, places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack or panic-like symptoms.

Panic Disorder Without Agoraphobia is characterized by recurrent unexpected Panic Attacks about which there is persistent concern. **Panic Disorder With Agoraphobia** is characterized by both recurrent unexpected Panic Attacks and Agoraphobia.

Agoraphobia Without History of Panic Disorder is characterized by the presence of Agoraphobia and panic-like symptoms without a history of unexpected Panic Attacks.

Specific Phobia is characterized by clinically significant anxiety provoked by exposure to a specific feared object or situation, often leading to avoidance behavior.

Social Phobia is characterized by clinically significant anxiety provoked by exposure to certain types of social or performance situations, often leading to avoidance behavior.

Obsessive-Compulsive Disorder is characterized by obsessions (which cause marked anxiety or distress) and/or by compulsions (which serve to neutralize anxiety).

Posttraumatic Stress Disorder is characterized by the reexperiencing of an extremely traumatic event accompanied by symptoms of increased arousal and by avoidance of stimuli associated with the trauma.

Acute Stress Disorder is characterized by symptoms similar to those of Posttraumatic Stress Disorder that occur immediately in the aftermath of an extremely traumatic event.

Generalized Anxiety Disorder is characterized by at least 6 months of persistent and excessive anxiety and worry.

Anxiety Disorder Due to a General Medical Condition is characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a general medical condition.

Substance-Induced Anxiety Disorder is characterized by prominent symptoms of anxiety that are judged to be a direct physiological consequence of a drug of abuse, a medication, or toxin exposure.

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

Because Separation Anxiety Disorder (characterized by anxiety related to separation from parental figures) usually develops in childhood, it is included in the "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" section (see p. 121). Phobic avoidance that is limited to genital sexual contact with a sexual partner is classified as Sexual Aversion Disorder and is included in the "Sexual and Gender Identity Disorders" section (see p. 541).

Panic Attack

Features

Because Panic Attacks can occur in the context of any Anxiety Disorder as well as other mental disorders (e.g., Mood Disorders, Substance-Related Disorders) and some general medical conditions (e.g., cardiac, respiratory, vestibular, gastrointestinal), the text and criteria set for a Panic Attack are provided separately in this section.

The essential feature of a Panic Attack is a discrete period of intense fear or discomfort in the absence of real danger that is accompanied by at least 4 of 13 somatic or cognitive symptoms. Symptoms can be somatic or cognitive in nature and include palpitations, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, chest pain or discomfort, nausea or abdominal distress, dizziness or lightheadedness, derealization or depersonalization, fear of losing control or "going crazy," fear of dying, paresthesias, and chills or hot flushes. The attack has a sudden onset and builds to a peak rapidly (usually in 10 minutes or less) and is often accompanied by a sense of imminent danger or impending doom and an urge to escape. The anxiety that is characteristic of a Panic Attack can be differentiated from generalized anxiety by its discrete, almost paroxysmal, nature and its typically greater severity. Attacks that meet all other criteria but that have fewer than 4 somatic or cognitive symptoms are referred to as limited-symptom attacks.

There are three characteristic types of Panic Attacks: unexpected (uncued), situationally bound (cued), and situationally predisposed. Each type of Panic Attack is defined by a different set of relationships between the onset of the attack and the presence or absence of situational triggers that can include cues that are either external (e.g., an individual with claustrophobia has an attack while in a elevator stuck between floors) or internal (e.g., catastrophic cognitions about the ramifications of heart palpitations). **Unexpected (uncued) Panic Attacks** are defined as those for which the individual does not associate onset with an internal or external situational trigger

(i.e., the attack is perceived as occurring spontaneously "out of the blue"). **Situationally bound (cued) Panic Attacks** are defined as those that almost invariably occur immediately on exposure to, or in anticipation of, the situational cue or trigger (e.g., a person with Social Phobia having a Panic Attack upon entering into or thinking about a public speaking engagement). **Situationally predisposed Panic Attacks** are similar to situationally bound Panic Attacks but are not invariably associated with the cue and do not necessarily occur immediately after the exposure (e.g., attacks are more likely to occur while driving, but there are times when the individual drives and does not have a Panic Attack or times when the Panic Attack occurs after driving for a half hour).

Individuals seeking care for unexpected Panic Attacks will usually describe the fear as intense and report that they thought they were about to die, lose control, have a heart attack or stroke, or "go crazy." They also usually report an urgent desire to flee from wherever the attack is occurring. With recurrent unexpected Panic Attacks, over time the attacks typically become situationally bound or predisposed, although unexpected attacks may persist.

The occurrence of unexpected Panic Attacks is required for a diagnosis of Panic Disorder (with or without Agoraphobia). Situationally bound and situationally predisposed attacks are frequent in Panic Disorder but also occur in the context of other Anxiety Disorders and other mental disorders. For example, situationally bound Panic Attacks are experienced by a majority of individuals with Social Phobia (e.g., the person experiences a Panic Attack each and every time she must speak in public) and Specific Phobias (e.g., the person with a Specific Phobia of dogs experiences a Panic Attack each and every time he encounters a barking dog), whereas situationally predisposed Panic Attacks most typically occur in Generalized Anxiety Disorder (e.g., after watching television news programs that warn of an economic slowdown, the person becomes overwhelmed with worries about his finances and escalates into a Panic Attack) and Posttraumatic Stress Disorder (e.g., a rape victim sometimes experiences Panic Attacks when faced with reminders of the traumatic event, such as seeing a man who reminds her of the assailant).

In determining the differential diagnostic significance of a Panic Attack, it is important to consider the context in which the Panic Attack occurs. The distinction between unexpected Panic Attacks and both situationally bound and situationally predisposed Panic Attacks is critical, since recurrent unexpected attacks are required for a diagnosis of Panic Disorder (see p. 433). Determining whether a history of Panic Attacks warrants a diagnosis of Panic Disorder is, however, complicated by the fact that an exclusive relationship does not always exist between the type of Panic Attack and the diagnosis. For instance, although a diagnosis of Panic Disorder definitionally requires that at least some of the Panic Attacks be unexpected, individuals with Panic Disorder frequently report also having situationally bound or situationally predisposed attacks. As such, careful consideration of the focus of anxiety associated with the Panic Attacks is also important in differential diagnosis. To illustrate, consider a woman who has a Panic Attack prior to a public speaking engagement. If this woman indicates that the focus of her anxiety was that she might die from an impending heart attack, then assuming other diagnostic criteria are met, she may have Panic Disorder. If on the other hand, this woman identifies the focus of anxiety as not the Panic Attack itself, but of being embarrassed and humiliated, then she may be more likely to have

Social Phobia. The diagnostic issues for boundary cases are discussed in the "Differential Diagnosis" sections of the texts for the disorders in which Panic Attacks may appear.

Criteria for Panic Attack

Note: A Panic Attack is not a codable disorder. Code the specific diagnosis in which the Panic Attack occurs (e.g., 300.21 Panic Disorder With Agoraphobia [p. 441]).

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

(1) palpitations, pounding heart, or accelerated heart rate
(2) sweating
(3) trembling or shaking
(4) sensations of shortness of breath or smothering
(5) feeling of choking
(6) chest pain or discomfort
(7) nausea or abdominal distress
(8) feeling dizzy, unsteady, lightheaded, or faint
(9) derealization (feelings of unreality) or depersonalization (being detached from oneself)
(10) fear of losing control or going crazy
(11) fear of dying
(12) paresthesias (numbness or tingling sensations)
(13) chills or hot flushes

Agoraphobia

Features

Because Agoraphobia occurs in the context of Panic Disorder With Agoraphobia and Agoraphobia Without History of Panic Disorder, the text and criteria set for Agoraphobia are provided separately in this section. The essential feature of Agoraphobia is anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack (see p. 430) or panic-like symptoms (e.g., fear of having a sudden attack of dizziness or a sudden attack of diarrhea) (Criterion A). The anxiety typically leads to a pervasive avoidance of a variety of situations that may include being alone outside the home or being home alone; being in a crowd of people; traveling in an automobile, bus, or airplane; or being on a bridge or in an elevator. Some individuals are able to expose themselves to the feared situations but endure these experiences with considerable dread. Often an individual is better able to confront a feared situation when accompanied by a companion (Criterion B). Individuals' avoidance of situations may impair their ability to travel to work or to carry out homemaking responsibilities (e.g., grocery shopping, taking children to the doctor). The anxiety or phobic avoidance is

not better accounted for by another mental disorder (Criterion C). The differential diagnosis to distinguish Agoraphobia from Social and Specific Phobia and from severe Separation Anxiety Disorder can be difficult because all of these conditions are characterized by avoidance of specific situations. The diagnostic issues for boundary cases are discussed in the "Differential Diagnosis" sections of the texts for the disorders in which avoidant behavior is an essential or associated feature.

Criteria for Agoraphobia

Note: Agoraphobia is not a codable disorder. Code the specific disorder in which the Agoraphobia occurs (e.g., 300.21 Panic Disorder With Agoraphobia [p. 441] or 300.22 Agoraphobia Without History of Panic Disorder [p. 441]).

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and traveling in a bus, train, or automobile.

   Note: Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia if the avoidance is limited to social situations.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

Panic Disorder

Diagnostic Features

The essential feature of Panic Disorder is the presence of recurrent, unexpected Panic Attacks (see p. 430) followed by at least 1 month of persistent concern about having another Panic Attack, worry about the possible implications or consequences of the Panic Attacks, or a significant behavioral change related to the attacks (Criterion A). The Panic Attacks are not due to the direct physiological effects of a substance (e.g., Caffeine Intoxication) or a general medical condition (e.g., hyperthyroidism) (Criterion C). Finally, the Panic Attacks are not better accounted for by another mental dis-

order (e.g., Specific or Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, or Separation Anxiety Disorder) (Criterion D). Depending on whether criteria are also met for Agoraphobia (see p. 433), 300.21 Panic Disorder With Agoraphobia or 300.01 Panic Disorder Without Agoraphobia is diagnosed (Criterion B).

An unexpected (spontaneous, uncued) Panic Attack is defined as one that an individual does not immediately associate with a situational trigger (i.e., it is perceived as occurring "out of the blue"). Situational triggers can include stimuli that are either external (e.g., a phobic object or situation) or internal (e.g., physiological arousal) to the individual. In some instances, although a situational trigger may be apparent to the clinician, it may not be readily identifiable to the individual experiencing the Panic Attack. For example, an individual may not immediately identify increased autonomic arousal induced by a hot, stuffy room, or feelings of faintness produced by quickly sitting up as triggers for a Panic Attack, and as such, these attacks are considered at the time to be unexpected. At least two unexpected Panic Attacks are required for the diagnosis, but most individuals have considerably more. Individuals with Panic Disorder frequently also have situationally predisposed Panic Attacks (i.e., those more likely to occur on, but not invariably associated with, exposure to a situational trigger). Situationally bound attacks (i.e., those that occur almost invariably and immediately on exposure to a situational trigger) can occur but are less common.

The frequency and severity of the Panic Attacks vary widely. For example, some individuals have moderately frequent attacks (e.g., once a week) that occur regularly for months at a time. Others report short bursts of more frequent attacks (e.g., daily for a week) separated by weeks or months without any attacks or with less frequent attacks (e.g., two each month) over many years. Limited-symptom attacks (i.e., attacks that are identical to "full" Panic Attacks except that the sudden fear or anxiety is accompanied by fewer than 4 of the 13 symptoms) are very common in individuals with Panic Disorder. Although the distinction between full Panic Attacks and limited-symptom attacks is somewhat arbitrary, full Panic Attacks are typically associated with greater morbidity (e.g., greater health care utilization, greater functional impairment, poorer quality of life). Most individuals who have limited-symptom attacks have had full Panic Attacks at some time during the course of the disorder.

Individuals with Panic Disorder display characteristic concerns or attributions about the implications or consequences of the Panic Attacks. Some fear that the attacks indicate the presence of an undiagnosed, life-threatening illness (e.g., cardiac disease, seizure disorder). Despite repeated medical testing and reassurance, they may remain frightened and unconvinced that they do not have a life-threatening illness. Others fear that the Panic Attacks are an indication that they are "going crazy" or losing control or are emotionally weak. Some individuals with recurrent Panic Attacks significantly change their behavior (e.g., quit a job, avoid physical exertion) in response to the attacks, but deny either fear of having another attack or concerns about the consequences of their Panic Attacks. Concerns about the next attack, or its implications, are often associated with development of avoidant behavior that may meet criteria for Agoraphobia (see p. 433), in which case Panic Disorder With Agoraphobia is diagnosed.

Associated Features and Disorders

Associated descriptive features and mental disorders. In addition to worry about Panic Attacks and their implications, many individuals with Panic Disorder also report constant or intermittent feelings of anxiety that are not focused on any specific situation or event. Others become excessively apprehensive about the outcome of routine activities and experiences, particularly those related to health or separation from loved ones. For example, individuals with Panic Disorder often anticipate a catastrophic outcome from a mild physical symptom or medication side effect (e.g., thinking that a headache indicates a brain tumor or a hypertensive crisis). Such individuals are also much less tolerant of medication side effects and generally need continued reassurance in order to take medication. In individuals whose Panic Disorder has not been treated or was misdiagnosed, the belief that they have an undetected life-threatening illness may lead to both chronic debilitating anxiety and excessive visits to health care facilities. This pattern can be both emotionally and financially disruptive.

In some cases, loss or disruption of important interpersonal relationships (e.g., leaving home to live on one's own, divorce) is associated with the onset or exacerbation of Panic Disorder. Demoralization is a common consequence, with many individuals becoming discouraged, ashamed, and unhappy about the difficulties of carrying out their normal routines. They often attribute this problem to a lack of "strength" or "character." This demoralization can become generalized to areas beyond specific panic-related problems. These individuals may frequently be absent from work or school for doctor and emergency-room visits, which can lead to unemployment or dropping out of school.

Reported rates for comorbid Major Depressive Disorder vary widely, ranging from 10% to 65% in individuals with Panic Disorder. In approximately one-third of individuals with both disorders, the depression precedes the onset of Panic Disorder. In the remaining two-thirds, depression occurs coincident with or following the onset of Panic Disorder. A subset of individuals may treat their anxiety with alcohol or medications, and some of them may develop a Substance-Related Disorder as a consequence.

Comorbidity with other Anxiety Disorders is also common, especially in clinical settings and in individuals with more severe Agoraphobia. Social Phobia and Generalized Anxiety Disorder have been reported in 15%–30% of individuals with Panic Disorder, Specific Phobia in 2%–20%, and Obsessive-Compulsive Disorder in up to 10%. Although the literature suggests that Posttraumatic Stress Disorder has been reported in 2%–10% of those with Panic Disorder, some evidence suggests that rates may be much higher when posttraumatic symptoms are systematically queried. Separation Anxiety Disorder in childhood has been associated with this disorder. Comorbidity and symptom overlap with Hypochondriasis are common.

Associated laboratory findings. No laboratory findings have been identified that are diagnostic of Panic Disorder. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Panic Disorder relative to control subjects. Some individuals with Panic Disorder show signs of compensated respiratory alkalosis (i.e., decreased carbon dioxide and decreased bicarbonate levels with

an almost normal pH). Panic Attacks in response to panic provocation procedures such as sodium lactate infusion or carbon dioxide inhalation are more common in individuals with Panic Disorder than in control subjects or individuals with Generalized Anxiety Disorder.

Associated physical examination findings and general medical conditions. Transient tachycardia and moderate elevation of systolic blood pressure may occur during some Panic Attacks. Studies have identified significant comorbidity between Panic Disorder and numerous general medical symptoms and conditions, including, but not limited to, dizziness, cardiac arrhythmias, hyperthyroidism, asthma, chronic obstructive pulmonary disease, and irritable bowel syndrome. However, the nature of the association (e.g., cause-and-effect) between Panic Disorder and these conditions remains unclear. Although studies have suggested that both mitral valve prolapse and thyroid disease are more common among individuals with Panic Disorder than in the general population, others have found no differences in prevalence.

Specific Culture and Gender Features

In some cultures, Panic Attacks may involve intense fear of witchcraft or magic. Panic Disorder as described here has been found in epidemiological studies throughout the world. Moreover, a number of conditions included in the "Glossary of Culture-Bound Syndromes" (see Appendix I) may be related to Panic Disorder. Some cultural or ethnic groups restrict the participation of women in public life, and this must be distinguished from Agoraphobia. Panic Disorder Without Agoraphobia is diagnosed twice as often and Panic Disorder With Agoraphobia three times as often in women as in men.

Prevalence

Although lifetime prevalence rates of Panic Disorder (With or Without Agoraphobia) in community samples have been reported to be as high as 3.5%, most studies have found rates between 1% and 2%. One-year prevalence rates are between 0.5% and 1.5%. The prevalence rates of Panic Disorder in clinical samples are considerably higher. For example, Panic Disorder is diagnosed in approximately 10% of individuals referred for mental health consultation. In general medical settings, prevalence rates vary from 10% to 30% in vestibular, respiratory, and neurology clinics to as high as 60% in cardiology clinics. Approximately one-third to one-half of individuals diagnosed with Panic Disorder in community samples also have Agoraphobia, although a much higher rate of Agoraphobia is encountered in clinical samples.

Course

Age at onset for Panic Disorder varies considerably, but is most typically between late adolescence and the mid-30s. There may be a bimodal distribution, with one peak in late adolescence and a second smaller peak in the mid-30s. A small number of cases begin in childhood, and onset after age 45 years is unusual but can occur. Retrospective descriptions by individuals seen in clinical settings suggest that the usual course

is chronic but waxing and waning. Some individuals may have episodic outbreaks with years of remission in between, and others may have continuous severe symptomatology. Limited symptom attacks may come to be experienced with greater frequency if the course of the Panic Disorder is chronic. Although Agoraphobia may develop at any point, its onset is usually within the first year of occurrence of recurrent Panic Attacks. The course of Agoraphobia and its relationship to the course of Panic Attacks are variable. In some cases, a decrease or remission of Panic Attacks may be followed closely by a corresponding decrease in agoraphobic avoidance and anxiety. In others, Agoraphobia may become chronic regardless of the presence or absence of Panic Attacks. Some individuals report that they can reduce the frequency of Panic Attacks by avoiding certain situations. Naturalistic follow-up studies of individuals treated in tertiary care settings (which may select for a poor-prognosis group) suggest that, at 6–10 years posttreatment, about 30% of individuals are well, 40%–50% are improved but symptomatic, and the remaining 20%–30% have symptoms that are the same or slightly worse.

Familial Pattern

First-degree biological relatives of individuals with Panic Disorder are up to 8 times more likely to develop Panic Disorder. If the age at onset of the Panic Disorder is before 20, first-degree relatives have been found to be up to 20 times more likely to have Panic Disorder. However, in clinical settings, as many as one-half to three-quarters of individuals with Panic Disorder do not have an affected first-degree biological elative. Twin studies indicate a genetic contribution to the development of Panic Disorder.

Differential Diagnosis

Panic Disorder is not diagnosed if the Panic Attacks are judged to be a direct physiological consequence of a general medical condition, in which case an **Anxiety Disorder Due to a General Medical Condition** is diagnosed (see p. 476). Examples of general medical conditions that can cause Panic Attacks include hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular dysfunctions, seizure disorders, and cardiac conditions (e.g., arrhythmias, supraventricular tachycardia). Appropriate laboratory tests (e.g., serum calcium levels for hyperparathyroidism) or physical examinations (e.g., for cardiac conditions) may be helpful in determining the etiological role of a general medical condition. Panic Disorder is not diagnosed if the Panic Attacks are judged to be a direct physiological consequence of a substance (i.e., a drug of abuse, a medication), in which case a **Substance-Induced Anxiety Disorder** is diagnosed (see p. 479). Intoxication with central nervous system stimulants (e.g., cocaine, amphetamines, caffeine) or cannabis and withdrawal from central nervous system depressants (e.g., alcohol, barbiturates) can precipitate a Panic Attack. However, if Panic Attacks continue to occur outside of the context of substance use (e.g., long after the effects of intoxication or withdrawal have ended), a diagnosis of Panic Disorder should be considered. In addition, because Panic Disorder may precede substance use in some individuals and may be associated with increased substance use for purposes of self-medication, a detailed history should be taken to determine

if the individual had Panic Attacks prior to excessive substance use. If this is the case, a diagnosis of Panic Disorder should be considered in addition to a diagnosis of Substance Dependence or Abuse. Features such as onset after age 45 years or the presence of atypical symptoms during a Panic Attack (e.g., vertigo, loss of consciousness, loss of bladder or bowel control, headaches, slurred speech, or amnesia) suggest the possibility that a general medical condition or a substance may be causing the Panic Attack symptoms.

Panic Disorder must be distinguished from other mental disorders (e.g., **other Anxiety Disorders** and **Psychotic Disorders**) that have Panic Attacks as an associated feature. By definition, Panic Disorder is characterized by recurrent, unexpected (spontaneous, uncued, "out of the blue") Panic Attacks. As discussed earlier (see p. 430), there are three types of Panic Attacks—unexpected, situationally bound, and situationally predisposed. The presence of recurrent unexpected Panic Attacks either initially or later in the course is required for the diagnosis of Panic Disorder. In contrast, Panic Attacks that occur in the context of other Anxiety Disorders are situationally bound or situationally predisposed (e.g., in **Social Phobia** cued by social situations; in **Specific Phobia** cued by an object or situation; in **Generalized Anxiety Disorder** cued by worry; in **Obsessive-Compulsive Disorder** cued by thoughts of or exposure to the object or situation related to an obsession [e.g., exposure to dirt in someone with an obsession about contamination]; in **Posttraumatic Stress Disorder** cued by stimuli recalling the stressor). In some cases, the individual may have difficulty identifying cues triggering a Panic Attack. For example, an individual with Posttraumatic Stress Disorder may have a Panic Attack triggered by cognitions or physiological symptoms similar to those that occurred at the time of the traumatic event (e.g., cardiac arrhythmias, feelings of detachment). These cues may not be easily associated by the individual with the triggering event. If the Panic Attacks occur only in situations that can be associated with the traumatic event, then the Panic Attacks should be attributed to the Posttraumatic Stress Disorder. For example, if a person who had been raped while at home alone experiences Panic Attacks only when others are not around, a diagnosis of Posttraumatic Stress Disorder should be considered instead of a diagnosis of Panic Disorder. However, if the person experiences unexpected Panic Attacks in other situations, then an additional diagnosis of Panic Disorder should be considered.

The focus of the anxiety also helps to differentiate Panic Disorder With Agoraphobia from other disorders characterized by avoidant behaviors. Agoraphobic avoidance is associated with anxiety about the possibility of having a Panic Attack or panic-like sensations, whereas avoidance in other disorders is associated with concern about the negative or harmful consequences arising from the feared object or situation (e.g., scrutiny, humiliation, and embarrassment in Social Phobia; falling from a high place in Specific Phobia of heights; separation from parents in **Separation Anxiety Disorder**; persecution in **Delusional Disorder**).

Differentiation of Specific Phobia, Situational Type, from Panic Disorder With Agoraphobia may be particularly difficult because both disorders may include Panic Attacks and avoidance of similar types of situations (e.g., driving, flying, public transportation, enclosed places). Prototypically, Panic Disorder With Agoraphobia is characterized by the initial onset of unexpected Panic Attacks and the subsequent avoidance of multiple situations thought to be likely triggers of the Panic Attacks.

Prototypically, Specific Phobia, Situational Type, is characterized by situational avoidance in the absence of recurrent unexpected Panic Attacks. Some presentations fall between these prototypes and require clinical judgment in the selection of the most appropriate diagnosis. Four factors can be helpful in making this judgment: the focus of anxiety, the type and number of Panic Attacks, the number of situations avoided, and the level of intercurrent anxiety. For example, an individual who had not previously feared or avoided elevators has a Panic Attack in an elevator and begins to dread going to work because of the need to take the elevator to his office on the 24th floor. If this individual subsequently has Panic Attacks only in elevators (even if the focus of anxiety is on the Panic Attack), then a diagnosis of Specific Phobia may be appropriate. If, however, the individual experiences unexpected Panic Attacks in other situations and begins to avoid or endure with dread other situations because of anxious anticipation of a Panic Attack, then a diagnosis of Panic Disorder With Agoraphobia would be warranted. Furthermore, the presence of pervasive apprehension about having a Panic Attack even when not anticipating exposure to a phobic situation also supports a diagnosis of Panic Disorder With Agoraphobia. If the individual has additional unexpected Panic Attacks in other situations but no additional avoidance or endurance with dread develops, then the appropriate diagnosis would be Panic Disorder Without Agoraphobia. If the focus of avoidance is not related to having a Panic Attack but concerns some other catastrophe (e.g., injury due to the elevator cable breaking), then an additional diagnosis of Specific Phobia may be considered.

Similarly, distinguishing between Social Phobia and Panic Disorder With Agoraphobia can be difficult, especially when there is avoidance only of social situations. For example, individuals with Panic Disorder With Agoraphobia and those with Social Phobia may both avoid crowded situations (e.g., large shopping centers, crowded parties). The focus of anxiety and the type of Panic Attacks can be helpful in making this distinction. For example, an individual who had not previously had a fear of public speaking has a Panic Attack while giving a talk and begins to dread giving presentations. If this individual subsequently has Panic Attacks only in social performance situations and if these attacks are accompanied by a fear of being embarrassed and humiliated, then a diagnosis of Social Phobia may be appropriate. If, however, the individual continues to experience unexpected Panic Attacks in other situations, then a diagnosis of Panic Disorder With Agoraphobia would be warranted. Individuals with Social Phobia fear scrutiny and rarely have a Panic Attack when alone (unless when anticipating a social situation), whereas individuals with Panic Disorder With Agoraphobia may be more anxious in situations where they must be without a trusted companion. In addition, nocturnal Panic Attacks that awaken an individual from sleep are characteristic of Panic Disorder.

When criteria are met for both Panic Disorder and another Anxiety or Mood Disorder, both disorders should be diagnosed. However, if unexpected Panic Attacks occur in the context of another disorder (e.g., Major Depressive Disorder or Generalized Anxiety Disorder) but are not accompanied by a month or more of fear of having additional attacks, associated concerns, or behavior change, the additional diagnosis of Panic Disorder is not made. Because individuals with Panic Disorder may self-medicate their symptoms, comorbid Substance-Related Disorders (most notably related to cannabis, alcohol, and cocaine) are not uncommon.

Diagnostic criteria for 300.01 Panic Disorder Without Agoraphobia

A. Both (1) and (2):

(1) recurrent unexpected Panic Attacks (see p. 432)

(2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

(a) persistent concern about having additional attacks

(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")

(c) a significant change in behavior related to the attacks

B. Absence of Agoraphobia (see p. 433).

C. The Panic Attacks 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., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Diagnostic criteria for 300.21 Panic Disorder With Agoraphobia

A. Both (1) and (2):

  (1) recurrent unexpected Panic Attacks (see p. 432)
  (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:

    (a) persistent concern about having additional attacks
    (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
    (c) a significant change in behavior related to the attacks

B. The presence of Agoraphobia (see p. 433).

C. The Panic Attacks 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., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

300.22 Agoraphobia Without History of Panic Disorder

Diagnostic Features

The essential features of Agoraphobia Without History of Panic Disorder are similar to those of Panic Disorder With Agoraphobia except that the focus of fear is on the occurrence of incapacitating or extremely embarrassing panic-like symptoms or limited-symptom attacks rather than full Panic Attacks. Individuals with this disorder have Agoraphobia (see p. 433) (Criterion A). The "panic-like symptoms" include any of the 13 symptoms listed for Panic Attack (see p. 432) or other symptoms that may be incapacitating or embarrassing (e.g., loss of bladder control, vomiting in public). For example, an individual may fear having a severe headache or cardiac symptoms and not being able to get help.

To qualify for this diagnosis, the full criteria for Panic Disorder must never have been met (Criterion B) and the symptoms must not be due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (Criterion C). If an associated general medical condition is present (e.g., a cardiac condition), the fear of being incapacitated or embarrassed by the development of

symptoms (e.g., fainting) is clearly in excess of that usually associated with the condition (Criterion D). When a diagnosis of Agoraphobia Without History of Panic Disorder is being made, it should be ensured that the avoidance is characteristic of Agoraphobia and cannot be better explained by another Axis I disorder (e.g., Specific Phobia or Social Phobia) or Axis II disorder (e.g., Avoidant Personality Disorder).

Specific Culture and Gender Features

Some cultural or ethnic groups restrict the participation of women in public life, and this must be distinguished from Agoraphobia. This disorder is diagnosed far more often in females than in males.

Prevalence

In clinical settings, almost all individuals (over 95%) who present with Agoraphobia also have a current diagnosis (or history) of Panic Disorder. In contrast, the prevalence of Agoraphobia Without History of Panic Disorder in epidemiological samples has been reported to be higher than that for Panic Disorder With Agoraphobia. However, problems with assessment appear to have inflated the rates reported in epidemiological studies. Recently, individuals who were given a diagnosis of Agoraphobia Without History of Panic Disorder in an epidemiological study were reevaluated by clinicians using standard interview schedules. The majority were found to have Specific Phobias, but not Agoraphobia.

Course

Relatively little is known about the course of Agoraphobia Without History of Panic Disorder. Anecdotal evidence suggests that some cases may persist for years and be associated with considerable impairment.

Differential Diagnosis

Agoraphobia Without History of Panic Disorder is distinguished from **Panic Disorder With Agoraphobia** by the absence of a history of recurrent unexpected Panic Attacks. The avoidance in Agoraphobia Without History of Panic Disorder results from fear of incapacitation or humiliation due to unpredictable, sudden, panic-like symptoms rather than from fear of a full Panic Attack as in Panic Disorder With Agoraphobia. The diagnosis of Panic Disorder With Agoraphobia remains appropriate in cases in which Panic Attacks go into remission but Agoraphobia continues to be experienced.

Other reasons for avoidance must also be distinguished from Agoraphobia Without History of Panic Disorder. In **Social Phobia,** individuals avoid social or performance situations in which they fear that they might act in a way that is humiliating or embarrassing. In **Specific Phobia,** the individual avoids a specific feared object or situation. In **Major Depressive Disorder,** the individual may avoid leaving home due to apathy, loss of energy, and anhedonia. Persecutory fears (as in **Delusional Disorder**) and fears of contamination (as in **Obsessive-Compulsive Disorder**) can

also lead to widespread avoidance. In **Separation Anxiety Disorder,** children avoid situations that take them away from home or close relatives.

Individuals with certain general medical conditions may avoid situations due to **realistic concerns** about being incapacitated (e.g., fainting in an individual with transient ischemic attacks) or being embarrassed (e.g., diarrhea in an individual with Crohn's disease). The diagnosis of Agoraphobia Without History of Panic Disorder should be given only if the fear or avoidance is clearly in excess of that usually associated with the general medical condition.

Diagnostic criteria for 300.22 Agoraphobia Without History of Panic Disorder

A. The presence of Agoraphobia (see p. 433) related to fear of developing panic-like symptoms (e.g., dizziness or diarrhea).

B. Criteria have never been met for Panic Disorder (see p. 440).

C. 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.

D. If an associated general medical condition is present, the fear described in Criterion A is clearly in excess of that usually associated with the condition.

300.29 Specific Phobia (*formerly* Simple Phobia)

Diagnostic Features

The essential feature of Specific Phobia is marked and persistent fear of clearly discernible, circumscribed objects or situations (Criterion A). Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response (Criterion B). This response may take the form of a situationally bound or situationally predisposed Panic Attack (see p. 430). Although adolescents and adults with this disorder recognize that their fear is excessive or unreasonable (Criterion C), this may not be the case with children. Most often, the phobic stimulus is avoided, although it is sometimes endured with dread (Criterion D). The diagnosis is appropriate only if the avoidance, fear, or anxious anticipation of encountering the phobic stimulus interferes significantly with the person's daily routine, occupational functioning, or social life, or if the person is markedly distressed about having the phobia (Criterion E). In individuals under age 18 years, symptoms must have persisted for at least 6 months before Specific Phobia is diagnosed (Criterion F). The anxiety, Panic Attacks, or phobic avoidance are not better accounted for by another mental disorder (e.g., Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Separation Anxiety Disorder, Social Phobia, Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder) (Criterion G).

The individual experiences a marked, persistent, and excessive or unreasonable fear when in the presence of, or when anticipating an encounter with, a specific object or situation. The focus of the fear may be anticipated harm from some aspect of the object or situation (e.g., an individual may fear air travel because of a concern about crashing, may fear dogs because of concerns about being bitten, or may fear driving because of concerns about being hit by other vehicles on the road). Specific Phobias may also involve concerns about losing control, panicking, somatic manifestations of anxiety and fear (such as increased heart rate or shortness of breath), and fainting that might occur on exposure to the feared object. For example, individuals afraid of blood and injury may also worry about the possibility of fainting; people afraid of heights may also worry about dizziness; and people afraid of closed-in situations may also worry about losing control and screaming. These concerns may be particularly strong in the Situational Type of Specific Phobia.

Anxiety is almost invariably felt immediately on confronting the phobic stimulus (e.g., a person with a Specific Phobia of cats will almost invariably have an immediate anxiety response when forced to confront a cat). The level of anxiety or fear usually varies as a function of both the degree of proximity to the phobic stimulus (e.g., fear intensifies as the cat approaches and decreases as the cat withdraws) and the degree to which escape from the phobic stimulus is limited (e.g., fear intensifies as the elevator approaches the midway point between floors and decreases as the doors open at the next floor). However, the intensity of the fear may not always relate predictably to the phobic stimulus (e.g., a person afraid of heights may experience variable amounts of fear when crossing the same bridge on different occasions). Sometimes full-blown Panic Attacks are experienced in response to the phobic stimulus, especially when the person must remain in the situation or believes that escape will be impossible. Occasionally, the Panic Attacks are delayed and do not occur immediately upon confronting the phobic stimulus. This delay is more likely in the Situational Type. Because marked anticipatory anxiety occurs if the person is confronted with the necessity of entering into the phobic situation, such situations are usually avoided. Less commonly, the person forces himself or herself to endure the phobic situation, but it is experienced with intense anxiety.

Adults with this disorder recognize that the phobia is excessive or unreasonable. The diagnosis would be Delusional Disorder instead of Specific Phobia for an individual who avoids an elevator because of a conviction that it has been sabotaged and who does not recognize that this fear is excessive and unreasonable. Moreover, the diagnosis should not be given if the fear is reasonable given the context of the stimuli (e.g., fear of being shot in a hunting area or a dangerous neighborhood). Insight into the excessive or unreasonable nature of the fear tends to increase with age and is not required to make the diagnosis in children.

Fears of circumscribed objects or situations are very common, especially in children, but in many cases the degree of impairment is insufficient to warrant a diagnosis. If the phobia does not significantly interfere with the individual's functioning or cause marked distress, the diagnosis is not made. For example, a person who is afraid of snakes to the point of expressing intense fear in the presence of snakes would not receive a diagnosis of Specific Phobia if he or she lives in an area devoid of snakes, is not restricted in activities by the fear of snakes, and is not distressed about having a fear of snakes.

Subtypes

The following subtypes may be specified to indicate the focus of fear or avoidance in Specific Phobia (e.g., Specific Phobia, Animal Type).

Animal Type. This subtype should be specified if the fear is cued by animals or insects. This subtype generally has a childhood onset.
Natural Environment Type. This subtype should be specified if the fear is cued by objects in the natural environment, such as storms, heights, or water. This subtype generally has a childhood onset.
Blood-Injection-Injury Type. This subtype should be specified if the fear is cued by seeing blood or an injury or by receiving an injection or other invasive medical procedure. This subtype is highly familial and is often characterized by a strong vasovagal response.
Situational Type. This subtype should be specified if the fear is cued by a specific situation such as public transportation, tunnels, bridges, elevators, flying, driving, or enclosed places. This subtype has a bimodal age-at-onset distribution, with one peak in childhood and another peak in the mid-20s. This subtype appears to be similar to Panic Disorder With Agoraphobia in its characteristic sex ratios, familial aggregation pattern, and age at onset.
Other Type. This subtype should be specified if the fear is cued by other stimuli. These stimuli might include the fear of choking, vomiting, or contracting an illness; "space" phobia (i.e., the individual is afraid of falling down if away from walls or other means of physical support); and children's fears of loud sounds or costumed characters.

The frequency of the subtypes in adult clinical settings, from most to least frequent, is Situational; Natural Environment; Blood-Injection-Injury; and Animal. Studies of community samples show a slightly different pattern, with phobias of heights and of spiders, mice, and insects most common, and phobias of other animals and other elements of the natural environment, such as storms, thunder, and lightning, least common. Phobias of closed-in situations (a Situational Type of phobia) may be more common in the elderly. In many cases, more than one subtype of Specific Phobia is present. Having one phobia of a specific subtype tends to increase the likelihood of having another phobia from within the same subtype (e.g., fear of cats *and* snakes). When more than one subtype applies, they should all be noted (e.g., Specific Phobia, Animal and Natural Environment Types).

Associated Features and Disorders

Associated descriptive features and mental disorders. Specific Phobia may result in a restricted lifestyle or interference with certain occupations, depending on the type of phobia. For example, job promotion may be threatened by avoidance of air travel, and social activities may be restricted by fears of crowded or closed-in places. Specific Phobias frequently co-occur with other Anxiety Disorders, Mood Disorders, and Substance-Related Disorders. For example, in community samples, rates of co-occurrence with other disorders range from 50% to 80%, and these rates may be high-

er among individuals with early-onset Specific Phobias. In clinical settings, Specific Phobias are very common comorbid diagnoses with other disorders. However, Specific Phobias are rarely the focus of clinical attention in these situations. The Specific Phobia is usually associated with less distress or less interference with functioning than the comorbid main diagnosis. Overall, only 12%–30% are estimated to seek professional help for their Specific Phobias. In the absence of other diagnoses, help seeking for Specific Phobias is more likely with more functionally impairing phobias (e.g., phobias of objects or situations that are commonly encountered), multiple phobias, and Panic Attacks in the phobic context. In contrast, individuals with irrational fears of blood injury, medical procedures, and medical settings may be less likely to seek help for phobias.

Associated physical examination findings and general medical conditions. A vasovagal fainting response is characteristic of Blood-Injection-Injury Type Specific Phobias; approximately 75% of such individuals report a history of fainting in these situations. The physiological response is characterized by an initial brief acceleration of heart rate and elevation in blood pressure followed by a deceleration of heart rate and a drop in blood pressure, which contrasts with the usual acceleration of heart rate and elevation in blood pressure in other Specific Phobias. Certain general medical conditions may be exacerbated as a consequence of phobic avoidance. For example, Specific Phobias, Blood-Injection-Injury Type, may have detrimental effects on dental or physical health, because the individual may avoid obtaining necessary medical care. Similarly, fears of choking may have a detrimental effect on health when food is limited to substances that are easy to swallow or when oral medication is avoided.

Specific Culture, Age, and Gender Features

The content of phobias varies with culture and ethnicity. For example, fears of magic or spirits are present in many cultures and should be considered a Specific Phobia only if the fear is excessive in the context of that culture and causes significant impairment or distress. Specific Phobias may be more common in the lower socioeconomic strata, although the data are mixed.

In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging. Children often do not recognize that the fears are excessive or unreasonable and rarely report distress about having the phobias. Fears of animals and other objects in the natural environment are particularly common and are usually transitory in childhood. A diagnosis of Specific Phobia is not warranted unless the fears lead to clinically significant impairment (e.g., unwillingness to go to school for fear of encountering a dog on the street).

Overall, the ratio of women to men with Specific Phobias is approximately 2:1, even among the elderly. However, the sex ratio varies across different types of Specific Phobias. Approximately 75%–90% of individuals with the Animal and Natural Environment Type are female (except for fear of heights, where the percentage of females is 55%–70%). Similarly, approximately 75%–90% of individuals with the Situational Type are female. Approximately 55%–70% of individuals with the Blood-Injection-Injury Type are female.

Prevalence

Although phobias are common in the general population, they rarely result in sufficient impairment or distress to warrant a diagnosis of Specific Phobia. The reported prevalence may vary depending on the threshold used to determine impairment or distress and the number of types of phobias surveyed. In community samples, current prevalence rates range from 4% to 8.8%, and lifetime prevalence rates range from 7.2% to 11.3%. Prevalence rates decline in the elderly. Also, prevalence estimates vary for different types of Specific Phobias.

Course

The first symptoms of a Specific Phobia usually occur in childhood or early adolescence and may occur at a younger age for women than for men. Also, the mean age at onset varies according to the type of Specific Phobia. Age at onset for Specific Phobia, Situational Type, tends to be bimodally distributed, with a peak in childhood and a second peak in the mid-20s. Specific Phobias, Natural Environment Type (e.g., height phobia), tend to begin primarily in childhood, although many new cases of height phobia develop in early adulthood. The ages at onset for Specific Phobias, Animal Type, and for Specific Phobias, Blood-Injection-Injury Type, are also usually in childhood. Fear of a stimulus is usually present for some time before becoming sufficiently distressing or impairing to be considered a Specific Phobia.

Predisposing factors to the onset of Specific Phobias include traumatic events (such as being attacked by an animal or trapped in a closet), unexpected Panic Attacks in the to-be-feared situation, observation of others undergoing trauma or demonstrating fearfulness (such as observing others fall from heights or become afraid in the presence of certain animals), and informational transmission (e.g., repeated parental warnings about the dangers of certain animals or media coverage of airplane crashes). Feared objects or situations tend to involve things that may actually represent a threat or have represented a threat at some point in the course of human evolution. Phobias that result from traumatic events or unexpected Panic Attacks tend to be particularly acute in their development. Phobias of traumatic origin do not have a characteristic age at onset (e.g., fear of choking, which usually follows a choking or near-choking incident, may develop at almost any age). Specific Phobias in adolescence increase the chances of either persistence of the Specific Phobia or development of additional Specific Phobias in early adulthood but do not predict the development of other disorders. Phobias that persist into adulthood remit only infrequently (around 20% of cases).

Familial Pattern

There is an increased risk for Specific Phobias in family members of those with Specific Phobias. Also, there is some evidence to suggest that there may be an aggregation within families by type of phobia (e.g., first-degree biological relatives of persons with Specific Phobias, Animal Type, are likely to have animal phobias, although not necessarily of the same animal, and first-degree biological relatives of persons with Specific Phobias, Situational Type, are likely to have phobias of situations). Fears of blood and injury have particularly strong familial patterns.

Differential Diagnosis

Specific Phobias differ from most other Anxiety Disorders in levels of intercurrent anxiety. Typically, individuals with Specific Phobia, unlike those with **Panic Disorder With Agoraphobia,** do not present with pervasive anxiety, because their fear is limited to specific, circumscribed objects or situations. However, generalized anxious anticipation may emerge under conditions in which encounters with the phobic stimulus become more likely (e.g., when a person who is fearful of snakes moves to a desert area) or when life events force immediate confrontation with the phobic stimulus (e.g., when a person who is fearful of flying is forced by circumstances to fly).

Differentiation of Specific Phobia, Situational Type, from Panic Disorder With Agoraphobia may be particularly difficult because both disorders may include Panic Attacks and avoidance of similar types of situations (e.g., driving, flying, public transportation, and enclosed places). Prototypically, Panic Disorder With Agoraphobia is characterized by the initial onset of unexpected Panic Attacks and the subsequent avoidance of multiple situations thought to be likely triggers of the Panic Attacks. Prototypically, Specific Phobia, Situational Type, is characterized by situational avoidance in the absence of recurrent unexpected Panic Attacks. Some presentations fall between these prototypes and require clinical judgment in the selection of the most appropriate diagnosis. Four factors can be helpful in making this judgment: the focus of fear, the type and number of Panic Attacks, the number of situations avoided, and the level of intercurrent anxiety. For example, an individual who had not previously feared or avoided elevators has a Panic Attack in an elevator and begins to dread going to work because of the need to take the elevator to his office on the 24th floor. If this individual subsequently has Panic Attacks only in elevators (even if the focus of fear is on the Panic Attack), then a diagnosis of Specific Phobia may be appropriate. If, however, the individual experiences unexpected Panic Attacks in other situations and begins to avoid or endure with dread other situations because of fear of a Panic Attack, then a diagnosis of Panic Disorder With Agoraphobia would be warranted. Furthermore, the presence of pervasive apprehension about having a Panic Attack even when not anticipating exposure to a phobic situation also supports a diagnosis of Panic Disorder With Agoraphobia. If the individual has additional unexpected Panic Attacks in other situations but no additional avoidance or endurance with dread develops, then the appropriate diagnosis would be Panic Disorder Without Agoraphobia.

Concurrent diagnoses of Specific Phobia and Panic Disorder With Agoraphobia are sometimes warranted. In these cases, consideration of the focus of the individual's concern about the phobic situation may be helpful. For example, avoidance of being alone because of concern about having unexpected Panic Attacks warrants a diagnosis of Panic Disorder With Agoraphobia (if other criteria are met), whereas the additional phobic avoidance of air travel, if due to worries about bad weather conditions and crashing, may warrant an additional diagnosis of Specific Phobia.

Specific Phobia and **Social Phobia** can be differentiated on the basis of the focus of the fears. For example, avoidance of eating in a restaurant may be based on concerns about negative evaluation from others (i.e., Social Phobia) or concerns about choking (i.e., Specific Phobia). In contrast to the avoidance in Specific Phobia, the avoidance in **Posttraumatic Stress Disorder** follows a life-threatening stressor and is accompa-

nied by additional features (e.g., reexperiencing the trauma and restricted affect). In **Obsessive-Compulsive Disorder,** the avoidance is associated with the content of the obsession (e.g., dirt, contamination). In individuals with **Separation Anxiety Disorder,** a diagnosis of Specific Phobia is not given if the avoidance behavior is exclusively limited to fears of separation from persons to whom the individual is attached. Moreover, children with Separation Anxiety Disorder often have associated exaggerated fears of people or events (e.g., of muggers, burglars, kidnappers, car accidents, airplane travel) that might threaten the integrity of the family. A separate diagnosis of Specific Phobia would rarely be warranted.

The differentiation between **Hypochondriasis** and a Specific Phobia, Other Type (i.e., avoidance of situations that may lead to contracting an illness), depends on the presence or absence of disease conviction. Individuals with Hypochondriasis are preoccupied with fears of having a disease, whereas individuals with a Specific Phobia fear contracting a disease (but do not believe it is already present). In individuals with **Anorexia Nervosa** and **Bulimia Nervosa,** a diagnosis of Specific Phobia is not given if the avoidance behavior is exclusively limited to avoidance of food and food-related cues. An individual with **Schizophrenia** or **another Psychotic Disorder** may avoid certain activities in response to delusions, but does not recognize that the fear is excessive or unreasonable.

Fears are very common, particularly in childhood, but they do not warrant a diagnosis of Specific Phobia unless there is significant interference with social, educational, or occupational functioning or marked distress about having the phobia.

Diagnostic criteria for 300.29 Specific Phobia

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

Diagnostic criteria for 300.29 Specific Phobia *(continued)*

G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Specify type:

Animal Type
Natural Environment Type (e.g., heights, storms, water)
Blood-Injection-Injury Type
Situational Type (e.g., airplanes, elevators, enclosed places)
Other Type (e.g., fear of choking, vomiting, or contracting an illness; in children, fear of loud sounds or costumed characters)

300.23 Social Phobia (Social Anxiety Disorder)

Diagnostic Features

The essential feature of Social Phobia is a marked and persistent fear of social or performance situations in which embarrassment may occur (Criterion A). Exposure to the social or performance situation almost invariably provokes an immediate anxiety response (Criterion B). This response may take the form of a situationally bound or situationally predisposed Panic Attack (see p. 430). Although adolescents and adults with this disorder recognize that their fear is excessive or unreasonable (Criterion C), this may not be the case with children. Most often, the social or performance situation is avoided, although it is sometimes endured with dread (Criterion D). The diagnosis is appropriate only if the avoidance, fear, or anxious anticipation of encountering the social or performance situation interferes significantly with the person's daily routine, occupational functioning, or social life, or if the person is markedly distressed about having the phobia (Criterion E). In individuals younger than age 18 years, symptoms must have persisted for at least 6 months before Social Phobia is diagnosed (Criterion F). The fear or avoidance is not due to the direct physiological effects of a substance or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder) (Criterion G). If another mental disorder or general medical condition is present (e.g., Stuttering, Parkinson's disease, Anorexia Nervosa), the fear or avoidance is not limited to concern about its social impact (Criterion H).

In feared social or performance situations, individuals with Social Phobia experience concerns about embarrassment and are afraid that others will judge them to be anxious, weak, "crazy," or stupid. They may fear public speaking because of concern

that others will notice their trembling hands or voice or they may experience extreme anxiety when conversing with others because of fear that they will appear inarticulate. They may avoid eating, drinking, or writing in public because of a fear of being embarrassed by having others see their hands shake. Individuals with Social Phobia almost always experience symptoms of anxiety (e.g., palpitations, tremors, sweating, gastrointestinal discomfort, diarrhea, muscle tension, blushing, confusion) in the feared social situations, and, in severe cases, these symptoms may meet the criteria for a Panic Attack (see p. 432). Blushing may be more typical of Social Phobia.

Adults with Social Phobia recognize that the fear is excessive or unreasonable, although this is not always the case in children. For example, the diagnosis would be Delusional Disorder instead of Social Phobia for an individual who avoids eating in public because of a conviction that he or she will be observed by the police and who does not recognize that this fear is excessive and unreasonable. Moreover, the diagnosis should not be given if the fear is reasonable given the context of the stimuli (e.g., fear of being called on in class when unprepared).

The person with Social Phobia typically will avoid the feared situations. Less commonly, the person forces himself or herself to endure the social or performance situation, but experiences it with intense anxiety. Marked anticipatory anxiety may also occur far in advance of upcoming social or public situations (e.g., worrying every day for several weeks before attending a social event). There may be a vicious cycle of anticipatory anxiety leading to fearful cognition and anxiety symptoms in the feared situations, which leads to actual or perceived poor performance in the feared situations, which leads to embarrassment and increased anticipatory anxiety about the feared situations, and so on.

The fear or avoidance must interfere significantly with the person's normal routine, occupational or academic functioning, or social activities or relationships, or the person must experience marked distress about having the phobia. For example, a person who is afraid of speaking in public would not receive a diagnosis of Social Phobia if this activity is not routinely encountered on the job or in the classroom and the person is not particularly distressed about it. Fears of being embarrassed in social situations are common, but usually the degree of distress or impairment is insufficient to warrant a diagnosis of Social Phobia. Transient social anxiety or avoidance is especially common in childhood and adolescence (e.g., an adolescent girl may avoid eating in front of boys for a short time, then resume usual behavior). In those younger than age 18 years, only symptoms that persist for at least 6 months qualify for the diagnosis of Social Phobia.

Specifier

Generalized. This specifier can be used when the fears are related to most social situations (e.g., initiating or maintaining conversations, participating in small groups, dating, speaking to authority figures, attending parties). Individuals with Social Phobia, Generalized, usually fear both public performance situations and social interactional situations. Because individuals with Social Phobia often do not spontaneously report the full range of their social fears, it is useful for the clinician to review a list of social and performance situations with the individual. Individuals whose clinical manifestations do not meet the

definition of Generalized compose a heterogeneous group (sometimes referred to in the literature as nongeneralized, circumscribed, or specific) that includes persons who fear a single performance situation as well as those who fear several, but not most, social situations. Individuals with Social Phobia, Generalized, may be more likely to manifest deficits in social skills and to have severe social and work impairment.

Associated Features and Disorders

Associated descriptive features and mental disorders. Common associated features of Social Phobia include hypersensitivity to criticism, negative evaluation, or rejection; difficulty being assertive; and low self-esteem or feelings of inferiority. Individuals with Social Phobia also often fear indirect evaluation by others, such as taking a test. They may manifest poor social skills (e.g., poor eye contact) or observable signs of anxiety (e.g., cold clammy hands, tremors, shaky voice). Individuals with Social Phobia often underachieve in school due to test anxiety or avoidance of classroom participation. They may underachieve at work because of anxiety during, or avoidance of, speaking in groups, in public, or to authority figures and colleagues. Persons with Social Phobia often have decreased social support networks and are less likely to marry. In more severe cases, individuals may drop out of school, be unemployed and not seek work due to difficulty interviewing for jobs, have no friends or cling to unfulfilling relationships, completely refrain from dating, or remain with their family of origin. Furthermore, Social Phobia may be associated with suicidal ideation, especially when comorbid disorders are present.

Social Phobia may be associated with other Anxiety Disorders, Mood Disorders, Substance-Related Disorders, and Bulimia Nervosa and usually precedes these disorders. In clinical samples, Avoidant Personality Disorder is frequently present in individuals with Social Phobia, Generalized.

Associated laboratory findings. Thus far, no laboratory test has been found to be diagnostic of Social Phobia, nor is there sufficient evidence to support the use of any laboratory test (e.g., lactate infusion, CO_2 inhalation) to distinguish Social Phobia from other Anxiety Disorders (e.g., Panic Disorder).

Specific Culture, Age, and Gender Features

Clinical presentation and resulting impairment may differ across cultures, depending on social demands. In certain cultures (e.g., Japan and Korea), individuals with Social Phobia may develop persistent and excessive fears of giving offense to others in social situations, instead of being embarrassed. These fears may take the form of extreme anxiety that blushing, eye-to-eye contact, or one's body odor will be offensive to others (*taijin kyofusho* in Japan).

In children, crying, tantrums, freezing, clinging or staying close to a familiar person, and inhibited interactions to the point of mutism may be present. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults. Unlike adults, children with Social Phobia usually do not have the option of avoiding feared situations altogether

and may be unable to identify the nature of their anxiety. There may be a decline in classroom performance, school refusal, or avoidance of age-appropriate social activities and dating. To make the diagnosis in children, there must be evidence of capacity for social relationships with familiar people and the social anxiety must occur in peer settings, not just in interactions with adults. Because of the disorder's early onset and chronic course, impairment in children tends to take the form of failure to achieve an expected level of functioning, rather than a decline from an optimal level of functioning. In contrast, when the onset is in adolescence, the disorder may lead to decrements in social and academic performance.

Epidemiological and community-based studies suggest that Social Phobia is more common in women than in men. In most clinical samples, however, the sexes are either equally represented or the majority are male.

Prevalence

Epidemiological and community-based studies have reported a lifetime prevalence of Social Phobia ranging from 3% to 13%. The reported prevalence may vary depending on the threshold used to determine distress or impairment and the number of types of social situations specifically surveyed. In one study, 20% reported excessive fear of public speaking and performance, but only about 2% appeared to experience enough impairment or distress to warrant a diagnosis of Social Phobia. In the general population, most individuals with Social Phobia fear public speaking, whereas somewhat less than half fear speaking to strangers or meeting new people. Other performance fears (e.g., eating, drinking, or writing in public, or using a public restroom) appear to be less common. In clinical settings, the vast majority of persons with Social Phobia fear more than one type of social situation. Social Phobia is rarely the reason for admission to inpatient settings. In outpatient clinics, rates of Social Phobia have ranged between 10% and 20% of individuals with Anxiety Disorders, but rates vary widely by site.

Course

Social Phobia typically has an onset in the mid-teens, sometimes emerging out of a childhood history of social inhibition or shyness. Some individuals report an onset in early childhood. Onset may abruptly follow a stressful or humiliating experience, or it may be insidious. The course of Social Phobia is often continuous. Duration is frequently lifelong, although the disorder may attenuate in severity or remit during adulthood. Severity of impairment may fluctuate with life stressors and demands. For example, Social Phobia may diminish after a person with fear of dating marries and reemerge after death of a spouse. A job promotion to a position requiring public speaking may result in the emergence of Social Phobia in someone who previously never needed to speak in public.

Familial Pattern

Social Phobia appears to occur more frequently among first-degree biological relatives of those with the disorder compared with the general population. Evidence for this is strongest for the Generalized subtype.

Differential Diagnosis

Individuals with both Panic Attacks and social avoidance sometimes present a potentially difficult diagnostic problem. Prototypically, **Panic Disorder With Agoraphobia** is characterized by the initial onset of unexpected Panic Attacks and the subsequent avoidance of multiple situations thought to be likely triggers of the Panic Attacks. Although social situations may be avoided in Panic Disorder due to the fear of being seen while having a Panic Attack, Panic Disorder is characterized by recurrent unexpected Panic Attacks that are not limited to social situations, and the diagnosis of Social Phobia is not made when the only social fear is of being seen while having a Panic Attack. Prototypically, Social Phobia is characterized by the avoidance of social situations in the absence of recurrent unexpected Panic Attacks. When Panic Attacks do occur, they take the form of situationally bound or situationally predisposed Panic Attacks (e.g., a person with fear of embarrassment when speaking in public experiences Panic Attacks cued only by public speaking or other social situations). Some presentations fall between these prototypes and require clinical judgment in the selection of the most appropriate diagnosis. For example, an individual who had not previously had a fear of public speaking has a Panic Attack while giving a talk and begins to dread giving presentations. If this individual subsequently has Panic Attacks only in social performance situations (even if the focus of fear is on the panic), then a diagnosis of Social Phobia may be appropriate. If, however, the individual continues to experience unexpected Panic Attacks, then a diagnosis of Panic Disorder With Agoraphobia would be warranted. If criteria are met for both Social Phobia and Panic Disorder, both diagnoses may be given. For example, an individual with lifelong fear and avoidance of most social situations (Social Phobia) later develops Panic Attacks in nonsocial situations and a variety of additional avoidance behaviors (Panic Disorder With Agoraphobia).

Avoidance of situations because of a fear of possible humiliation is highly prominent in Social Phobia, but may also at times occur in **Panic Disorder With Agoraphobia** and **Agoraphobia Without History of Panic Disorder.** The situations avoided in Social Phobia are limited to those involving possible scrutiny by other people. Fears in Agoraphobia Without History of Panic Disorder typically involve characteristic clusters of situations that may or may not involve scrutiny by others (e.g., being alone outside the home or being home alone; being on a bridge or in an elevator; traveling in a bus, train, automobile, or airplane). The role of a companion also may be useful in distinguishing Social Phobia from Agoraphobia (With and Without Panic Disorder). Typically, individuals with agoraphobic avoidance prefer to be with a trusted companion when in the feared situation, whereas individuals with Social Phobia may have marked anticipatory anxiety, but characteristically do not have Panic Attacks when alone. A person with Social Phobia who fears crowded stores would feel scrutinized with or without a companion and might be less anxious without the added burden of perceived scrutiny by the companion.

Children with **Separation Anxiety Disorder** may avoid social settings due to concerns about being separated from their caretaker, concerns about being embarrassed by needing to leave prematurely to return home, or concerns about requiring the presence of a parent when it is not developmentally appropriate. A separate diagnosis of Social Phobia is generally not warranted. Children with Separation Anxiety Dis-

order are usually comfortable in social settings in their own home, whereas those with Social Phobia display signs of discomfort even when feared social situations occur at home.

Although fear of embarrassment or humiliation may be present in **Generalized Anxiety Disorder** or **Specific Phobia** (e.g., embarrassment about fainting when having blood drawn), this is not the main focus of the individual's fear or anxiety. Children with Generalized Anxiety Disorder have excessive worries about the quality of their performance, but these occur even when they are not evaluated by others, whereas in Social Phobia the potential evaluation by others is the key to the anxiety.

In a **Pervasive Developmental Disorder** and **Schizoid Personality Disorder,** social situations are avoided because of lack of interest in relating to other individuals. In contrast, individuals with Social Phobia have a capacity for and interest in social relationships with familiar people. In particular, for children to qualify for a diagnosis of Social Phobia, they must have at least one age-appropriate social relationship with someone outside the immediate family (e.g., a child who feels uncomfortable in social gatherings with peers and avoids such situations, but who has an active interest in and a relationship with one familiar same-age friend).

Avoidant Personality Disorder shares a number of features with Social Phobia and appears to overlap extensively with Social Phobia, Generalized. Avoidant Personality Disorder may be a more severe variant of Social Phobia, Generalized, that is not qualitatively distinct. For individuals with Social Phobia, Generalized, the additional diagnosis of Avoidant Personality Disorder should be considered.

Social anxiety and avoidance of social situations are **associated features of many other mental disorders** (e.g., Major Depressive Disorder, Dysthymic Disorder, Schizophrenia, Body Dysmorphic Disorder). If the symptoms of social anxiety or avoidance occur only during the course of another mental disorder and are judged to be better accounted for by that disorder, the additional diagnosis of Social Phobia is not made.

Some individuals may experience clinically significant social anxiety and avoidance related to a general medical condition or mental disorder with potentially embarrassing symptoms (e.g., tremor in Parkinson's disease, Stuttering, obesity, strabismus, facial scarring, or abnormal eating behavior in Anorexia Nervosa). However, if social anxiety and avoidance are limited to concerns about the general medical condition or mental disorder, by convention the diagnosis of Social Phobia is not made. If the social avoidance is clinically significant, a separate diagnosis of **Anxiety Disorder Not Otherwise Specified** may be given.

Performance anxiety, stage fright, and **shyness** in social situations that involve unfamiliar people are common and should not be diagnosed as Social Phobia unless the anxiety or avoidance leads to clinically significant impairment or marked distress. Children commonly exhibit social anxiety, particularly when interacting with unfamiliar adults. A diagnosis of Social Phobia should not be made in children unless the social anxiety is also evident in peer settings and persists for at least 6 months.

Diagnostic criteria for 300.23 Social Phobia

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder)

300.3 Obsessive-Compulsive Disorder

Diagnostic Features

The essential features of Obsessive-Compulsive Disorder are recurrent obsessions or compulsions (Criterion A) that are severe enough to be time consuming (i.e., they take more than 1 hour a day) or cause marked distress or significant impairment (Cri-

terion C). At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable (Criterion B). If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (Criterion 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 (Criterion E).

Obsessions are persistent ideas, thoughts, impulses, or images that are experienced as intrusive and inappropriate and that cause marked anxiety or distress. The intrusive and inappropriate quality of the obsessions has been referred to as "ego-dystonic." This refers to the individual's sense that the content of the obsession is alien, not within his or her own control, and not the kind of thought that he or she would expect to have. However, the individual is able to recognize that the obsessions are the product of his or her own mind and are not imposed from without (as in thought insertion).

The most common obsessions are repeated thoughts about contamination (e.g., becoming contaminated by shaking hands), repeated doubts (e.g., wondering whether one has performed some act such as having hurt someone in a traffic accident or having left a door unlocked), a need to have things in a particular order (e.g., intense distress when objects are disordered or asymmetrical), aggressive or horrific impulses (e.g., to hurt one's child or to shout an obscenity in church), and sexual imagery (e.g., a recurrent pornographic image). The thoughts, impulses, or images are not simply excessive worries about real-life problems (e.g., concerns about current ongoing difficulties in life, such as financial, work, or school problems) and are unlikely to be related to a real-life problem.

The individual with obsessions usually attempts to ignore or suppress such thoughts or impulses or to neutralize them with some other thought or action (i.e., a compulsion). For example, an individual plagued by doubts about having turned off the stove attempts to neutralize them by repeatedly checking to ensure that it is off.

Compulsions are repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) the goal of which is to prevent or reduce anxiety or distress, not to provide pleasure or gratification. In most cases, the person feels driven to perform the compulsion to reduce the distress that accompanies an obsession or to prevent some dreaded event or situation. For example, individuals with obsessions about being contaminated may reduce their mental distress by washing their hands until their skin is raw; individuals distressed by obsessions about having left a door unlocked may be driven to check the lock every few minutes; individuals distressed by unwanted blasphemous thoughts may find relief in counting to 10 backward and forward 100 times for each thought. In some cases, individuals perform rigid or stereotyped acts according to idiosyncratically elaborated rules without being able to indicate why they are doing them. By definition, compulsions are either clearly excessive or are not connected in a realistic way with what they are designed to neutralize or prevent. The most common compulsions involve washing and cleaning, counting, checking, requesting or demanding assurances, repeating actions, and ordering.

By definition, adults with Obsessive-Compulsive Disorder have at some point recognized that the obsessions or compulsions are excessive or unreasonable. This requirement does not apply to children because they may lack sufficient cognitive awareness to make this judgment. However, even in adults there is a broad range of

insight into the reasonableness of the obsessions or compulsions. Some individuals are uncertain about the reasonableness of their obsessions or compulsions, and any given individual's insight may vary across times and situations. For example, the person may recognize a contamination compulsion as unreasonable when discussing it in a "safe situation" (e.g., in the therapist's office), but not when forced to handle money. At those times when the individual recognizes that the obsessions and compulsions are unreasonable, he or she may desire or attempt to resist them. When attempting to resist a compulsion, the individual may have a sense of mounting anxiety or tension that is often relieved by yielding to the compulsion. In the course of the disorder, after repeated failure to resist the obsessions or compulsions, the individual may give in to them, no longer experience a desire to resist them, and may incorporate the compulsions into his or her daily routines.

The obsessions or compulsions must cause marked distress, be time consuming (take more than 1 hour per day), or significantly interfere with the individual's normal routine, occupational functioning, or usual social activities or relationships with others. Obsessions or compulsions can displace useful and satisfying behavior and can be highly disruptive to overall functioning. Because obsessive intrusions can be distracting, they frequently result in inefficient performance of cognitive tasks that require concentration, such as reading or computation. In addition, many individuals avoid objects or situations that provoke obsessions or compulsions. Such avoidance can become extensive and can severely restrict general functioning.

Specifier

With Poor Insight. This specifier can be applied when, for most of the time during the current episode, the individual does not recognize that the obsessions or compulsions are excessive or unreasonable.

Associated Features and Disorders

Associated descriptive features and mental disorders. Frequently there is avoidance of situations that involve the content of the obsessions, such as dirt or contamination. For example, a person with obsessions about dirt may avoid public restrooms or shaking hands with strangers. Hypochondriacal concerns are common, with repeated visits to physicians to seek reassurance. Guilt, a pathological sense of responsibility, and sleep disturbances may be present. There may be excessive use of alcohol or of sedative, hypnotic, or anxiolytic medications. Performing compulsions may become a major life activity, leading to serious marital, occupational, or social disability. Pervasive avoidance may leave an individual housebound.

In adults, Obsessive-Compulsive Disorder may be associated with Major Depressive Disorder, some other Anxiety Disorders (i.e., Specific Phobia, Social Phobia, Panic Disorder, Generalized Anxiety Disorder), Eating Disorders, and some Personality Disorders (i.e., Obsessive-Compulsive Personality Disorder, Avoidant Personality Disorder, Dependent Personality Disorder). In children, it may also be associated with Learning Disorders and Disruptive Behavior Disorders. There is a high incidence of Obsessive-Compulsive Disorder in children and adults with Tourette's

Disorder, with estimates ranging from approximately 35% to 50%. The incidence of Tourette's Disorder in Obsessive-Compulsive Disorder is lower, with estimates ranging between 5% and 7%. Between 20% and 30% of individuals with Obsessive-Compulsive Disorder have reported current or past tics.

Associated laboratory findings. No laboratory findings have been identified that are diagnostic of Obsessive-Compulsive Disorder. However, a variety of laboratory findings have been noted to be abnormal in groups of individuals with Obsessive-Compulsive Disorder relative to control subjects. There is some evidence that some serotonin agonists given acutely cause increased symptoms in some individuals with the disorder. Individuals with the disorder may exhibit increased autonomic activity when confronted in the laboratory with circumstances that trigger an obsession. Physiological reactivity decreases after the performance of compulsions.

Associated physical examination findings and general medical conditions. Dermatological problems caused by excessive washing with water or caustic cleaning agents may be observed.

Specific Culture, Age, and Gender Features

Culturally prescribed ritual behavior is not in itself indicative of Obsessive-Compulsive Disorder unless it exceeds cultural norms, occurs at times and places judged inappropriate by others of the same culture, and interferes with social role functioning. Although cultural factors may not lead to Obsessive-Compulsive Disorder per se, religious and cultural beliefs may influence the themes of obsessions and compulsions (e.g., Orthodox Jews with religious compulsions may have symptoms focusing on dietary practices). Important life transitions and mourning may lead to an intensification of ritual behavior that may appear to be an obsession to a clinician who is not familiar with the cultural context.

Presentations of Obsessive-Compulsive Disorder in children are generally similar to those in adulthood. Washing, checking, and ordering rituals are particularly common in children. Children generally do not request help, and the symptoms may not be ego-dystonic. More often the problem is identified by parents, who bring the child in for treatment. Gradual declines in schoolwork secondary to impaired ability to concentrate have been reported. Like adults, children are more prone to engage in rituals at home than in front of peers, teachers, or strangers. For a small subset of children, Obsessive-Compulsive Disorder may be associated with Group A beta-hemolytic streptococcal infection (e.g., scarlet fever and "strep throat"). This form of Obsessive-Compulsive Disorder is characterized by prepubertal onset, associated neurological abnormalities (e.g., choreiform movements and motoric hyperactivity) and an abrupt onset of symptoms or an episodic course in which exacerbations are temporally related to the streptococcal infections. Older adults tend to show more obsessions concerning morality and washing rituals compared with other types of symptoms.

In adults, this disorder is equally common in males and females. However, in childhood-onset Obsessive-Compulsive Disorder, the disorder is more common in boys than in girls.

Prevalence

Community studies have estimated a lifetime prevalence of 2.5% and a 1-year prevalence of 0.5%–2.1% in adults. However, methodological problems with the assessment tool used raise the possibility that the true prevalence rates are much lower. Community studies of children and adolescents have estimated a lifetime prevalence of 1%–2.3% and a 1-year prevalence of 0.7%. Research indicates that prevalence rates of Obsessive-Compulsive Disorder are similar in many different cultures around the world.

Course

Although Obsessive-Compulsive Disorder usually begins in adolescence or early adulthood, it may begin in childhood. Modal age at onset is earlier in males than in females: between ages 6 and 15 years for males and between ages 20 and 29 years for females. For the most part, onset is gradual, but acute onset has been noted in some cases. The majority of individuals have a chronic waxing and waning course, with exacerbation of symptoms that may be related to stress. About 15% show progressive deterioration in occupational and social functioning. About 5% have an episodic course with minimal or no symptoms between episodes.

Familial Pattern

The concordance rate for Obsessive-Compulsive Disorder is higher for monozygotic twins than it is for dizygotic twins. The rate of Obsessive-Compulsive Disorder in first-degree biological relatives of individuals with Obsessive-Compulsive Disorder and in first-degree biological relatives of individuals with Tourette's Disorder is higher than that in the general population.

Differential Diagnosis

Obsessive-Compulsive Disorder must be distinguished from **Anxiety Disorder Due to a General Medical Condition.** The diagnosis is Anxiety Disorder Due to a General Medical Condition when the obsessions or compulsions are judged to be a direct physiological consequence of a specific general medical condition (see p. 476). This determination is based on history, laboratory findings, or physical examination. A **Substance-Induced Anxiety Disorder** is distinguished from Obsessive-Compulsive Disorder by the fact that a substance (i.e., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the obsessions or compulsions (see p. 479).

Recurrent or intrusive thoughts, impulses, images, or behaviors may occur in the context of many other mental disorders. Obsessive-Compulsive Disorder is not diagnosed if the content of the thoughts or the activities is exclusively related to another mental disorder (e.g., preoccupation with appearance in **Body Dysmorphic Disorder,** preoccupation with a feared object or situation in **Specific** or **Social Phobia,** hair pulling in **Trichotillomania**). An additional diagnosis of Obsessive-Compulsive Disorder may still be warranted if there are obsessions or compulsions whose content is unrelated to the other mental disorder.

In a **Major Depressive Episode,** persistent brooding about potentially unpleasant circumstances or about possible alternative actions is common and is considered a mood-congruent aspect of depression rather than an obsession. For example, a depressed individual who ruminates that he is worthless would not be considered to have obsessions because such brooding is not ego-dystonic.

Generalized Anxiety Disorder is characterized by excessive worry, but such worries are distinguished from obsessions by the fact that the person experiences them as excessive concerns about real-life circumstances. For example, an excessive concern that one may lose one's job would constitute a worry, not an obsession. In contrast, the content of obsessions does not typically involve real-life problems, and the obsessions are experienced as inappropriate by the individual (e.g., the intrusive distressing idea that "God" is "dog" spelled backward).

If recurrent distressing thoughts are exclusively related to fears of having, or the idea that one has, a serious disease based on misinterpretation of bodily symptoms, then **Hypochondriasis** should be diagnosed instead of Obsessive-Compulsive Disorder. However, if the concern about having an illness is accompanied by rituals such as excessive washing or checking behavior related to concerns about the illness or about spreading it to other people, then an additional diagnosis of Obsessive-Compulsive Disorder may be indicated. If the major concern is about contracting an illness (rather than having an illness) and no rituals are involved, then a **Specific Phobia** of illness may be the more appropriate diagnosis.

The ability of individuals to recognize that the obsessions or compulsions are excessive or unreasonable occurs on a continuum. In some individuals with Obsessive-Compulsive Disorder, 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). In such cases, the presence of psychotic features may be indicated by an additional diagnosis of **Delusional Disorder** or **Psychotic Disorder Not Otherwise Specified.** The specifier With Poor Insight may be useful in those situations that are on the boundary between obsession and delusion (e.g., an individual whose extreme preoccupation with contamination, although exaggerated, is less intense than in a Delusional Disorder and is justified by the fact that germs are indeed ubiquitous).

The ruminative delusional thoughts and bizarre stereotyped behaviors that occur in **Schizophrenia** are distinguished from obsessions and compulsions by the fact that they are not ego-dystonic and not subject to reality testing. However, some individuals manifest symptoms of both Obsessive-Compulsive Disorder and Schizophrenia and warrant both diagnoses.

Tics (in **Tic Disorder**) and stereotyped movements (in **Stereotypic Movement Disorder**) must be distinguished from compulsions. A *tic* is a sudden, rapid, recurrent, nonrhythmic stereotyped motor movement or vocalization (e.g., eye blinking, tongue protrusion, throat clearing). A *stereotyped movement* is a repetitive, seemingly driven nonfunctional motor behavior (e.g., head banging, body rocking, self-biting). In contrast to a compulsion, tics and stereotyped movements are typically less complex and are not aimed at neutralizing an obsession. Some individuals manifest symptoms of both Obsessive-Compulsive Disorder and a Tic Disorder (especially Tourette's Disorder), and both diagnoses may be warranted.

Some activities, such as eating (e.g., **Eating Disorders**), sexual behavior (e.g.,

Paraphilias), gambling (e.g., **Pathological Gambling**), or substance use (e.g., **Alcohol Dependence** or **Abuse**), when engaged in excessively, have been referred to as "compulsive." However, these activities are not considered to be compulsions as defined in this manual because the person usually derives pleasure from the activity and may wish to resist it only because of its deleterious consequences.

Although **Obsessive-Compulsive Personality Disorder** and Obsessive-Compulsive Disorder have similar names, the clinical manifestations of these disorders are quite different. Obsessive-Compulsive Personality Disorder is not characterized by the presence of obsessions or compulsions and instead involves a pervasive pattern of preoccupation with orderliness, perfectionism, and control and must begin by early adulthood. If an individual manifests symptoms of both Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder, both diagnoses can be given.

Superstitions and **repetitive checking behaviors** are commonly encountered in everyday life. A diagnosis of Obsessive-Compulsive Disorder should be considered only if they are particularly time consuming or result in clinically significant impairment or distress.

Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

Diagnostic criteria for 300.3 Obsessive-Compulsive Disorder *(continued)*

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

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 if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

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309.81 Posttraumatic Stress Disorder

Diagnostic Features

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe

automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event can be replayed or otherwise represented (Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). These episodes, often referred to as "flashbacks," are typically brief but can be associated with prolonged distress and heightened arousal. Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering any elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situations, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outbursts of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3).

Specifiers

The following specifiers may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

Acute. This specifier should be used when the duration of symptoms is less than 3 months.

Chronic. This specifier should be used when the symptoms last 3 months or longer.

With Delayed Onset. This specifier indicates that at least 6 months have passed between the traumatic event and the onset of the symptoms.

Associated Features and Disorders

Associated descriptive features and mental disorders. Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Avoidance patterns may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. Auditory hallucinations and paranoid ideation can be present in some severe and chronic cases. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

Posttraumatic Stress Disorder is associated with increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, Specific Phobia, and Bipolar Disorder. These disorders can either precede, follow, or emerge concurrently with the onset of Posttraumatic Stress Disorder.

Associated laboratory findings. Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

Associated physical examination findings and general medical conditions. Physical injuries may occur as a direct consequence of the trauma. In addition, chronic Posttraumatic Stress Disorder may be associated with increased rates of somatic complaints and, possibly, general medical conditions.

Specific Culture and Age Features

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation"—that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms, such as stomachaches and headaches.

Prevalence

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder of approximately 8% of the adult population in the United States. Information is not currently available with regard to the general population prevalence in other countries. Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

Course

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, a person's reaction to a trauma initially meets criteria for Acute Stress Disorder (see p. 469) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma. In some cases, the course is characterized by a waxing and waning of symptoms. Symptom reactivation may occur in response to reminders of the original trauma, life stressors, or new traumatic events.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Familial Pattern

There is evidence of a heritable component to the transmission of Posttraumatic Stress Disorder. Furthermore, a history of depression in first-degree relatives has

been related to an increased vulnerability to developing Postraumatic Stress Disorder.

Differential Diagnosis

In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder,** the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., a Mood Disorder or another Anxiety Disorder). Moreover, if the symptom response pattern to the extreme stressor meets criteria for **another mental disorder** (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

Acute Stress Disorder is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1 month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder.

In **Obsessive-Compulsive Disorder,** there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features,** a **delirium, Substance-Induced Disorders,** and **Psychotic Disorders Due to a General Medical Condition.**

Malingering should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

  (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

  (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

Diagnostic criteria for 309.81 Posttraumatic Stress Disorder *(continued)*

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places, or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (e.g., unable to have loving feelings)
(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months
Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

308.3 Acute Stress Disorder

Diagnostic Features

The essential feature of Acute Stress Disorder is the development of characteristic anxiety, dissociative, and other symptoms that occurs within 1 month after exposure to an extreme traumatic stressor (Criterion A). For a discussion of the types of stressors involved, see the description of Posttraumatic Stress Disorder (p. 463). Either while experiencing the traumatic event or after the event, the individual has at least three of the following dissociative symptoms: a subjective sense of numbing, detachment, or absence of emotional responsiveness; a reduction in awareness of his or her surroundings; derealization; depersonalization; or dissociative amnesia (Criterion B). Following the trauma, the traumatic event is persistently reexperienced (Criterion C), and the individual displays marked avoidance of stimuli that may arouse recollections of the trauma (Criterion D) and has marked symptoms of anxiety or increased arousal (Criterion E). The symptoms must cause clinically significant distress, significantly interfere with normal functioning, or impair the individual's ability to pursue necessary tasks (Criterion F). The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks after the traumatic event (Criterion G); if symptoms persist beyond 4 weeks, the diagnosis of Posttraumatic Stress Disorder may be applied. The symptoms are not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication) or a general medical condition, are not better accounted for by Brief Psychotic Disorder, and are not merely an exacerbation of a preexisting mental disorder (Criterion H).

As a response to the traumatic event, the individual develops dissociative symptoms. Individuals with Acute Stress Disorder may have a decrease in emotional responsiveness, often finding it difficult or impossible to experience pleasure in previously enjoyable activities, and frequently feel guilty about pursuing usual life tasks. They may experience difficulty concentrating, feel detached from their bodies, experience the world as unreal or dreamlike, or have increasing difficulty recalling specific details of the traumatic event (dissociative amnesia). In addition, at least one symptom from each of the symptom clusters required for Posttraumatic Stress Disorder is present. First, the traumatic event is persistently reexperienced (e.g., recurrent recollections, images, thoughts, dreams, illusions, flashback episodes, a sense of reliving the event, or distress on exposure to reminders of the event). Second, reminders of the trauma (e.g., places, people, activities) are avoided. Finally, hyperarousal in response to stimuli reminiscent of the trauma is present (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, an exaggerated startle response, and motor restlessness).

Associated Features and Disorders

Associated descriptive features and mental disorders. Symptoms of despair and hopelessness may be experienced in Acute Stress Disorder and may be sufficiently severe and persistent to meet criteria for a Major Depressive Episode, in which case an additional diagnosis of Major Depressive Disorder may be warranted. If the trauma

led to another's death or to serious injury, survivors may feel guilt about having remained intact or about not providing enough help to others. Individuals with this disorder often perceive themselves to have greater responsibility for the consequences of the trauma than is warranted. Problems may result from the individual's neglect of basic health and safety needs associated with the aftermath of the trauma. Individuals with this disorder are at increased risk for the development of Posttraumatic Stress Disorder. Rates of Posttraumatic Stress Disorder of approximately 80% have been reported for motor vehicle crash survivors and victims of violent crime whose response to the trauma initially met criteria for Acute Stress Disorder. Impulsive and risk-taking behavior may occur after the trauma.

Associated physical examination findings and general medical conditions. General medical conditions may occur as a consequence of the trauma (e.g., head injury, burns).

Specific Culture Features

Although some events are likely to be universally experienced as traumatic, the severity and pattern of response may be modulated by cultural differences in the implications of loss. There may also be culturally prescribed coping behaviors that are characteristic of particular cultures. For example, dissociative symptoms may be a more prominent part of the acute stress response in cultures in which such behaviors are sanctioned. For further discussion of cultural factors related to traumatic events, see p. 465.

Prevalence

The prevalence of Acute Stress Disorder in a population exposed to a serious traumatic stress depends on the severity and persistence of the trauma and the degree of exposure to it. The prevalence of Acute Stress Disorder in the general population is not known. In the few available studies, rates ranging from 14% to 33% have been reported in individuals exposed to severe trauma (i.e., being in a motor vehicle accident, being a bystander at a mass shooting).

Course

Symptoms of Acute Stress Disorder are experienced during or immediately after the trauma, last for at least 2 days, and either resolve within 4 weeks after the conclusion of the traumatic event or the diagnosis is changed. When symptoms persist beyond 1 month, a diagnosis of Posttraumatic Stress Disorder may be appropriate if the full criteria for Posttraumatic Stress Disorder are met. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors in determining the likelihood of development of Acute Stress Disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Acute Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

Differential Diagnosis

Some symptomatology following exposure to an extreme stress is ubiquitous and often does not require any diagnosis. Acute Stress Disorder should only be considered if the symptoms last at least 2 days and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning or impair the individual's ability to pursue some necessary task (e.g., obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience).

Acute Stress Disorder must be distinguished from a **Mental Disorder Due to a General Medical Condition** (e.g., head trauma) (see p. 181) and from a **Substance-Induced Disorder** (e.g., related to Alcohol Intoxication) (see p. 209), which may be common consequences of exposure to an extreme stressor. In some individuals, psychotic symptoms may occur following an extreme stressor. In such cases, **Brief Psychotic Disorder** is diagnosed instead of Acute Stress Disorder. If a **Major Depressive Episode** develops after the trauma, a diagnosis of Major Depressive Disorder should be considered in addition to a diagnosis of Acute Stress Disorder. A separate diagnosis of Acute Stress Disorder should not be made if the symptoms are an **exacerbation of a preexisting mental disorder.**

By definition, a diagnosis of Acute Stress Disorder is appropriate only for symptoms that occur within 1 month of the extreme stressor. Because **Posttraumatic Stress Disorder** requires more than 1 month of symptoms, this diagnosis cannot be made during this initial 1-month period. For individuals with the diagnosis of Acute Stress Disorder whose symptoms persist for longer than 1 month, the diagnosis of Posttraumatic Stress Disorder should be considered. For individuals who have an extreme stressor but who develop a symptom pattern that does not meet criteria for Acute Stress Disorder, a diagnosis of **Adjustment Disorder** should be considered.

Malingering must be ruled out in those situations in which financial remuneration, benefit eligibility, or forensic determinations play a role.

Diagnostic criteria for 308.3 Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")
   (3) derealization
   (4) depersonalization
   (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

Diagnostic criteria for 308.3 Acute Stress Disorder *(continued)*

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. 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, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

300.02 Generalized Anxiety Disorder (Includes Overanxious Disorder of Childhood)

Diagnostic Features

The essential feature of Generalized Anxiety Disorder is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least 6 months, about a number of events or activities (Criterion A). The individual finds it difficult to control the worry (Criterion B). The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep (only one additional symptom is required in children) (Criterion C). The focus of the anxiety and worry is not confined to features of another Axis I disorder such as having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder (Criterion D). Although individuals with Generalized Anxiety Disorder may not always identify the worries as "excessive," they report subjective distress due to constant worry, have

difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning (Criterion E). The disturbance is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) or a general medical condition and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder (Criterion F).

The intensity, duration, or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping the worry. Adults with Generalized Anxiety Disorder often worry about everyday, routine life circumstances such as possible job responsibilities, finances, the health of family members, misfortune to their children, or minor matters (such as household chores, car repairs, or being late for appointments). Children with Generalized Anxiety Disorder tend to worry excessively about their competence or the quality of their performance. During the course of the disorder, the focus of worry may shift from one concern to another.

Associated Features and Disorders

Associated with muscle tension, there may be trembling, twitching, feeling shaky, and muscle aches or soreness. Many individuals with Generalized Anxiety Disorder also experience somatic symptoms (e.g., sweating, nausea, or diarrhea) and an exaggerated startle response. Symptoms of autonomic hyperarousal (e.g., accelerated heart rate, shortness of breath, dizziness) are less prominent in Generalized Anxiety Disorder than in other Anxiety Disorders, such as Panic Disorder and Posttraumatic Stress Disorder. Depressive symptoms are also common.

Generalized Anxiety Disorder very frequently co-occurs with Mood Disorders (e.g., Major Depressive Disorder or Dysthymic Disorder), with other Anxiety Disorders (e.g., Panic Disorder, Social Phobia, Specific Phobia), and with Substance-Related Disorders (e.g., Alcohol or Sedative, Hypnotic, or Anxiolytic Dependence or Abuse). Other conditions that may be associated with stress (e.g., irritable bowel syndrome, headaches) frequently accompany Generalized Anxiety Disorder.

Specific Culture, Age, and Gender Features

There is considerable cultural variation in the expression of anxiety (e.g., in some cultures, anxiety is expressed predominantly through somatic symptoms, in others through cognitive symptoms). It is important to consider the cultural context when evaluating whether worries about certain situations are excessive.

In children and adolescents with Generalized Anxiety Disorder, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events, even when their performance is not being evaluated by others. There may be excessive concerns about punctuality. They may also worry about catastrophic events such as earthquakes or nuclear war. Children with the disorder may be overly conforming, perfectionist, and unsure of themselves and tend to redo tasks because of excessive dissatisfaction with less-than-perfect performance. They are typically overzealous in seeking approval and require excessive reassurance about their performance and their other worries.

Generalized Anxiety Disorder may be overdiagnosed in children. In considering this diagnosis in children, a thorough evaluation for the presence of other childhood Anxiety Disorders should be done to determine whether the worries may be better explained by one of these disorders. Separation Anxiety Disorder, Social Phobia, and Obsessive-Compulsive Disorder are often accompanied by worries that may mimic those described in Generalized Anxiety Disorder. For example, a child with Social Phobia may be concerned about school performance because of fear of humiliation. Worries about illness may also be better explained by Separation Anxiety Disorder or Obsessive-Compulsive Disorder.

In clinical settings, the disorder is diagnosed somewhat more frequently in women than in men (about 55%–60% of those presenting with the disorder are female). In epidemiological studies, the sex ratio is approximately two-thirds female.

Prevalence

In a community sample, the 1-year prevalence rate for Generalized Anxiety Disorder was approximately 3%, and the lifetime prevalence rate was 5%. In anxiety disorder clinics, up to a quarter of the individuals have Generalized Anxiety Disorder as a presenting or comorbid diagnosis.

Course

Many individuals with Generalized Anxiety Disorder report that they have felt anxious and nervous all their lives. Although over half of those presenting for treatment report onset in childhood or adolescence, onset occurring after age 20 years is not uncommon. The course is chronic but fluctuating and often worsens during times of stress.

Familial Pattern

Anxiety as a trait has a familial association. Although early studies produced inconsistent findings regarding familial patterns for Generalized Anxiety Disorder, more recent twin studies suggest a genetic contribution to the development of this disorder. Furthermore, genetic factors influencing risk of Generalized Anxiety Disorder may be closely related to those for Major Depressive Disorder.

Differential Diagnosis

Generalized Anxiety Disorder must be distinguished from an **Anxiety Disorder Due to a General Medical Condition.** The diagnosis is Anxiety Disorder Due to a General Medical Condition if the anxiety symptoms are judged to be a direct physiological consequence of a specific general medical condition (e.g., pheochromocytoma, hyperthyroidism) (see p. 476). This determination is based on history, laboratory findings, or physical examination. A **Substance-Induced Anxiety Disorder** is distinguished from Generalized Anxiety Disorder by the fact that a substance (i.e., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the anxiety disturbance (see p. 479). For example, severe anxiety that occurs only in the context