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

Research criteria for dissociative trance disorder

A. Either (1) or (2):

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

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

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

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

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

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

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

Binge-Eating Disorder

Diagnostic Features

The essential features are recurrent episodes of binge eating associated with subjective and behavioral indicators of impaired control over, and significant distress about, the binge eating and the absence of the regular use of inappropriate compensatory behaviors (such as self-induced vomiting, misuse of laxatives and other medications, fasting, and excessive exercise) that are characteristic of Bulimia Nervosa. The characteristics of a binge episode are discussed in the text for Bulimia Nervosa (p. 589). Indicators of impaired control include eating very rapidly, eating until feeling uncomfortably full, eating large amounts of food when not hungry, eating alone because of embarrassment over how much one is eating, and feeling disgust, guilt, or

depression after overeating. The marked distress required for the diagnosis includes unpleasant feelings during and after the binge episodes, as well as concerns about the long-term effect of the recurrent binge episodes on body weight and shape.

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

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

Associated Features and Disorders

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

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

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

In samples drawn from weight-control programs, the overall prevalence varies from approximately 15% to 50% (with a mean of 30%), with females approximately 1.5 times more likely to have this eating pattern than males. In nonpatient community samples, a prevalence rate of 0.7%–4% has been reported. The onset of binge eating

typically is in late adolescence or in the early 20s, often coming soon after significant weight loss from dieting. Among individuals presenting for treatment, the course appears to be chronic.

Differential Diagnosis

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

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

Research criteria for binge-eating disorder

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

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

B. The binge-eating episodes are associated with three (or more) of the following:

   (1) eating much more rapidly than normal
   (2) eating until feeling uncomfortably full
   (3) eating large amounts of food when not feeling physically hungry
   (4) eating alone because of being embarrassed by how much one is eating
   (5) feeling disgusted with oneself, depressed, or very guilty after overeating

C. Marked distress regarding binge eating is present.

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

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

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

Depressive Personality Disorder

Features

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

Associated Features

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

Differential Diagnosis

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

It remains controversial whether the distinction between depressive personality disorder and **Dysthymic Disorder** is useful. The research criteria given for this proposed disorder differ from the diagnostic criteria for Dysthymic Disorder by their emphasis on cognitive, interpersonal, and intrapsychic personality traits. This proposed disorder should not be considered if the symptoms are better accounted for by Dysthymic Disorder or if they occur exclusively during **Major Depressive Episodes.** This proposed disorder differs from so-called normal depressive traits (e.g., unhap-

piness, pessimism, self-criticism, and proneness to guilt) in that the pattern is pervasive and causes marked distress or impairment in social or occupational functioning. The relationship between this proposed disorder and several other proposed categories included in this appendix (i.e., minor depressive disorder, recurrent brief depressive disorder, mixed anxiety-depressive disorder, and Dysthymic Disorder when the alternative criteria set also provided within this appendix is used) and with other Personality Disorders is not known, but substantial overlap may exist among them.

Research criteria for depressive personality disorder

A. A pervasive pattern of depressive cognitions and behaviors beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

   (1) usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness
   (2) self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem
   (3) is critical, blaming, and derogatory toward self
   (4) is brooding and given to worry
   (5) is negativistic, critical, and judgmental toward others
   (6) is pessimistic
   (7) is prone to feeling guilty or remorseful

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

Passive-Aggressive Personality Disorder (Negativistic Personality Disorder)

Features

The essential feature is a pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance in social and occupational situations that begins by early adulthood and that occurs in a variety of contexts. This pattern does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder. These individuals habitually resent, oppose, and resist demands to function at a level expected by others. This opposition occurs most frequently in work situations but can also be evident in social functioning. The resistance is expressed by procrastination, forgetfulness, stubbornness, and intentional inefficiency, especially in response to tasks assigned by authority figures. These individuals obstruct the efforts of others by failing to do their share of the work. For example, when an executive gives a subordinate some material to review for a meeting the next morning, the subordinate may misplace or misfile the material rather than point out that there is insufficient time to do the work. These individuals feel cheated,

unappreciated, and misunderstood and chronically complain to others. When difficulties appear, they blame their failures on the behaviors of others. They may be sullen, irritable, impatient, argumentative, cynical, skeptical, and contrary. Authority figures (e.g., a superior at work, a teacher at school, a parent, or a spouse who acts the role of a parent) often become the focus of discontent. Because of their negativism and tendency to externalize blame, these individuals often criticize and voice hostility toward authority figures with minimal provocation. They are also envious and resentful of peers who succeed or who are viewed positively by authority figures. These individuals often complain about their personal misfortunes. They have a negative view of the future and may make comments such as, "It doesn't pay to be good" and "Good things don't last." These individuals may waver between expressing hostile defiance toward those they view as causing their problems and attempting to mollify these persons by asking forgiveness or promising to perform better in the future.

Associated Features

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

Differential Diagnosis

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

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

Research criteria for passive-aggressive personality disorder

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

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

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

Medication-Induced Movement Disorders

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

The term *neuroleptic* is used broadly in this manual to refer to medications with dopamine-antagonist properties. Although this term is becoming outdated because it highlights the propensity of antipsychotic medications to cause abnormal movements, the term neuroleptic remains appropriate. While newer antipsychotic medi-

cations are less likely to cause Medication-Induced Movement Disorders, these syndromes still occur. Neuroleptic medications include so-called conventional or typical antipsychotic agents (e.g., chlorpromazine, haloperidol, fluphenazine), the newer "atypical" antipsychotic agents (e.g., clozapine, risperidone, olanzapine, quetiapine), certain dopamine receptor blocking drugs used in the treatment of physical symptoms such as nausea (e.g., prochlorperazine, promethazine, trimethobenzamide, metoclopramide), and amoxapine, which is marketed as an antidepressant.

332.1 Neuroleptic-Induced Parkinsonism

Diagnostic Features

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

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

Parkinsonian muscular rigidity is defined as excessive firmness and tensing of resting muscles. It may affect all skeletal muscles or it may only involve discrete muscular areas. Two kinds of rigidity occur: *continuous ("lead-pipe") rigidity* and *cogwheel rigidity*. In lead-pipe rigidity, the limb or joint resists movement and feels locked in

place. The rigidity is continuous (i.e., the limb usually does not show moment-to-moment fluctuations). In cogwheel rigidity, as the muscle is stretched around a joint there is a rhythmic, ratchet-like resistance that interrupts the usual smooth motion of the joint. Cogwheel rigidity can be felt by placing the hand over the joint being moved. Cogwheel rigidity occurs when the muscles are passively moved, is most common in the wrists and elbows, and often waxes and wanes. Individuals with parkinsonian rigidity may complain of generalized muscle tenderness or stiffness, muscle or joint pain, body aching, or lack of coordination during sports.

Akinesia is a state of decreased spontaneous motor activity. There is global slowing as well as slowness in initiating and executing movements. Normal everyday behaviors (e.g., grooming) are reduced. Individuals may complain of feeling listless, lacking spontaneity and drive, or oversleeping. Parkinsonian rigidity and akinesia can be manifested as abnormalities in gait or decreases in length of stride, arm swing, or overall spontaneity of walking. Other signs include bent-over neck, stooped shoulders, a staring facial expression, and small shuffling steps. Drooling may arise due to a general decrease in pharyngeal motor activity, although it may be less common in parkinsonism associated with neuroleptic medication because of the anticholinergic properties of these medications. Subtle, behavioral manifestations of akinesia can mimic, or worsen, negative symptoms of Schizophrenia.

Associated Features

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

Differential Diagnosis

It is important to distinguish between Neuroleptic-Induced Parkinsonism and other causes of parkinsonian symptoms in individuals being treated with a neuroleptic medication. Neuroleptic-Induced Parkinsonism should be distinguished from **parkinsonian symptoms due to another substance or medication** or **due to a neurological or other general medical condition** (e.g., Parkinson's disease, Wilson's disease).

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

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

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

lation of signs and symptoms, including a characteristic walk and facial expression, drooling, decreased blinking, and other aspects of bradykinesia.

Research criteria for 332.1 Neuroleptic-Induced Parkinsonism

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

   (1) parkinsonian tremor (i.e., a coarse, rhythmic, resting tremor with a frequency between 3 and 6 cycles per second, affecting the limbs, head, mouth, or tongue)
   (2) parkinsonian muscular rigidity (i.e., cogwheel rigidity or continuous "lead-pipe" rigidity)
   (3) akinesia (i.e., a decrease in spontaneous facial expressions, gestures, speech, or body movements)

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

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

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

333.92 Neuroleptic Malignant Syndrome

Diagnostic Features

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

and are not better accounted for by a mental disorder (e.g., Mood Disorder With Catatonic Features). There may be accompanying agitation or acute dystonic reactions.

Elevated temperature ranges from mild elevations (e.g., 99°–100°F) to markedly hyperthermic states (e.g., 106°F). Fever due to a general medical condition (e.g., infection) needs to be ruled out as a cause of the elevated temperature; however, individuals with Neuroleptic Malignant Syndrome often develop other medical conditions that can worsen an already elevated temperature. CPK is typically elevated, ranging from minor elevations to extremely high levels (exceeding 16,000 IU). It should be noted that mild to moderate elevations of CPK can also be seen with muscle damage due to various causes such as intramuscular injection and use of restraints and has also been reported in individuals with acute Psychotic Disorders. White blood cell counts are often high, usually ranging between 10,000 and 20,000. In severe cases, myoglobinuria may occur and may be a harbinger of renal failure.

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

Associated Features

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

Estimates of the prevalence of this condition in individuals exposed to neuroleptic medications range from 0.07% to 1.4%. Neuroleptic Malignant Syndrome has been reported to occur somewhat more frequently in males than in females. The condition may occur at any age but has been reported most frequently in young adults. Varia-

tions in reported prevalence may be due to a lack of consistency in the definition of caseness, neuroleptic prescribing practices, study design, and the demographics of the population being studied. Neuroleptic Malignant Syndrome may occur more frequently with high-potency neuroleptic medication. Some individuals who have developed this condition may be less likely to be compliant with taking neuroleptic medication. Although many individuals do not experience a recurrence when neuroleptic medication is reinstituted, some do experience a recurrence, especially when the neuroleptic medication is reinstituted soon after an episode of Neuroleptic Malignant Syndrome.

Differential Diagnosis

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

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

Individuals with Schizophrenia or a Manic Episode who are not receiving a neuroleptic medication may sometimes present with extreme catatonic states (so-called **lethal catatonia**), which can mimic Neuroleptic Malignant Syndrome and may in-

clude elevated temperature, autonomic dysfunction, and abnormal laboratory findings. For individuals already receiving a neuroleptic medication, a history of prior extreme catatonic states when the individual was not receiving a neuroleptic is important in making the differential diagnosis. The problem is further confounded by the fact that neuroleptic medication may worsen the symptoms of lethal catatonia.

Research criteria for 333.92 Neuroleptic Malignant Syndrome

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

B. Two (or more) of the following:

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

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

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

333.7 Neuroleptic-Induced Acute Dystonia

Diagnostic Features

The essential feature of Neuroleptic-Induced Acute Dystonia is sustained abnormal postures or muscle spasms that develop in association with the use of neuroleptic medication. These include abnormal positioning of the head and neck in relation to the body (e.g., retrocollis, torticollis); spasms of the jaw muscles (trismus, gaping, grimacing); impaired swallowing (dysphagia), speaking, or breathing (potentially life-threatening laryngeal-pharyngeal spasm, dysphonia); thickened or slurred speech due to hypertonic tongue (dysarthria, macroglossia); tongue protrusion or tongue dysfunction; eyes deviated up, down, or sideward (oculogyric crisis); or abnormal positioning of the distal limbs or trunk (opisthotonos). There is great variability in the severity of the symptoms and in the body areas that may be affected. Increased tone in the affected muscles is usually present. The signs or symptoms develop within 7 days of starting or rapidly raising the dose of neuroleptic medication or of reducing

a medication being used to treat or prevent acute extrapyramidal symptoms (e.g., anticholinergic agents). The symptoms must not be better accounted for by a mental disorder (e.g., catatonic symptoms in Schizophrenia) and must not be due to a nonneuroleptic substance or to a neurological or other general medical condition.

Associated Features

Fear and anxiety often accompany the onset of Neuroleptic-Induced Acute Dystonia, especially in individuals who are unaware of the possibility of developing dystonia and who mistakenly regard the symptom as part of their mental disorder. Some individuals experience pain or cramps in affected muscles. Noncompliance with medication treatment may result following the development of acute dystonic reactions. Neuroleptic-Induced Acute Dystonia occurs most commonly in young males. Risk factors for developing Neuroleptic-Induced Acute Dystonia include prior dystonic reactions to neuroleptic treatment and the use of high-potency typical neuroleptic medication. Neuroleptic-Induced Acute Dystonia is far less likely to occur with atypical neuroleptic medications (i.e., fewer than 5% of treated individuals).

Differential Diagnosis

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

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

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

Research criteria for 333.7 Neuroleptic-Induced Acute Dystonia

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

   (1) abnormal positioning of the head and neck in relation to the body (e.g., retrocollis, torticollis)
   (2) spasms of the jaw muscles (trismus, gaping, grimacing)
   (3) impaired swallowing (dysphagia), speaking, or breathing (laryngeal-pharyngeal spasm, dysphonia)
   (4) thickened or slurred speech due to hypertonic or enlarged tongue (dysarthria, macroglossia)
   (5) tongue protrusion or tongue dysfunction
   (6) eyes deviated up, down, or sideward (oculogyric crisis)
   (7) abnormal positioning of the distal limbs or trunk

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

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

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

333.99 Neuroleptic-Induced Acute Akathisia

Diagnostic Features

The essential features of Neuroleptic-Induced Acute Akathisia are subjective complaints of restlessness and at least one of the following observed movements: fidgety movements or swinging of the legs while seated, rocking from foot to foot or "walking on the spot" while standing, pacing to relieve the restlessness, or an inability to sit or stand still for at least several minutes. In its most severe form, the individual may be unable to maintain any position for more than a few seconds. The subjective complaints include a sense of inner restlessness, most often in the legs; a compulsion to move one's legs; distress if one is asked not to move one's legs; and dysphoria and anxiety. The symptoms typically occur within 4 weeks of initiating or increasing the dose of a neuroleptic medication and can occasionally follow the reduction of medi-

cation used to treat or prevent acute extrapyramidal symptoms (e.g., anticholinergic agents). The symptoms are not better accounted for by a mental disorder (e.g., Schizophrenia, Substance Withdrawal, agitation from a Major Depressive or Manic Episode, hyperactivity in Attention-Deficit/Hyperactivity Disorder) and are not due to a nonneuroleptic substance or to a neurological or other general medical condition (e.g., Parkinson's disease, iron-deficiency anemia).

Associated Features and Disorders

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

Differential Diagnosis

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

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

ication will often exacerbate akathisia, whereas it often temporarily relieves the symptoms of Tardive Dyskinesia.

Neuroleptic-Induced Acute Akathisia should be distinguished from symptoms that are better accounted for by a mental disorder. Individuals with **Depressive Episodes, Manic Episodes, Generalized Anxiety Disorder, Schizophrenia and other Psychotic Disorders, Attention-Deficit/Hyperactivity Disorder, dementia, delirium, Substance Intoxication** (e.g., with cocaine), or **Substance Withdrawal** (e.g., from an opioid) may also display agitation that is difficult to distinguish from akathisia. Some of these individuals are able to differentiate akathisia from the anxiety, restlessness, and agitation characteristic of a mental disorder by their experience of akathisia as being different from previously experienced feelings. Other evidence that restlessness or agitation may be better accounted for by a mental disorder includes the onset of agitation prior to exposure to the neuroleptic medication, absence of increasing restlessness with increasing neuroleptic medication doses, and absence of relief with pharmacological interventions (e.g., no improvement after decreasing the neuroleptic dose or treatment with medication intended to treat the akathisia).

Research criteria for 333.99 Neuroleptic-Induced Acute Akathisia

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

B. At least one of the following is observed:

   (1) fidgety movements or swinging of the legs
   (2) rocking from foot to foot while standing
   (3) pacing to relieve restlessness
   (4) inability to sit or stand still for at least several minutes

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

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

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

333.82 Neuroleptic-Induced Tardive Dyskinesia

Diagnostic Features

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

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

Associated Features

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

The overall prevalence of Neuroleptic-Induced Tardive Dyskinesia in individuals who have received long-term neuroleptic treatment ranges from 20% to 30%. The overall incidence among younger individuals ranges from 3% to 5% per year. Middle-age and elderly individuals appear to develop Neuroleptic-Induced Tardive Dyskinesia more often, with prevalence figures reported up to 50% and an incidence of

25%–30% after an average of 1 year's cumulative exposure to neuroleptic medication. Prevalence also varies depending on setting, with Tardive Dyskinesia tending to be more common among inpatients (especially chronically institutionalized individuals). Variations in reported prevalence may be due to a lack of consistency in the definition of caseness, neuroleptic prescribing practices, study design, and the demographics of the population being studied.

There is no obvious gender difference in the susceptibility to Tardive Dyskinesia, although the risk may be somewhat greater in postmenopausal women. Greater cumulative amounts of typical neuroleptics and early development of extrapyramidal side effects are two of the most consistent risk factors for Tardive Dyskinesia. Mood Disorders (especially Major Depressive Disorder), neurological conditions, and Alcohol Dependence have also been found to be risk factors in some groups of individuals. There is growing evidence that the newer atypical neuroleptics are associated with a much lower incidence of Tardive Dyskinesia than the typical neuroleptics.

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

Differential Diagnosis

Dyskinesia that emerges during neuroleptic withdrawal may remit with continued withdrawal from neuroleptic medication. If the dyskinesia persists for at least 4 weeks, a diagnosis of Tardive Dyskinesia may be warranted. Neuroleptic-Induced Tardive Dyskinesia must be distinguished from other causes of orofacial and body dyskinesia. These conditions include **Huntington's disease; Wilson's disease; Sydenham's (rheumatic) chorea; systemic lupus erythematosus; thyrotoxicosis; heavy metal poisoning; ill-fitting dentures; dyskinesia due to other medications such as L-dopa, bromocriptine,** or **amantadine;** and **spontaneous dyskinesias.** Factors that may be helpful in making the distinction are evidence that the symptoms preceded the exposure to the neuroleptic medication or that other focal neurological signs are present. It should be noted that other movement disorders may coexist with Neuroleptic-Induced Tardive Dyskinesia. Because spontaneous dyskinesia can occur in more than 5% of individuals and is also more common in elderly persons, it may be difficult to prove that neuroleptic medications produced Tardive Dyskinesia in a given individ-

ual. Neuroleptic-Induced Tardive Dyskinesia must be distinguished from symptoms that are due to a neuroleptic-induced acute movement disorder (e.g., **Neuroleptic-Induced Acute Dystonia** or **Neuroleptic-Induced Acute Akathisia**). Neuroleptic-Induced Acute Dystonia develops within 7 days and Neuroleptic-Induced Acute Akathisia develops within 4 weeks of initiating or increasing the dose of a neuroleptic medication (or reducing the dose of a medication used to treat acute extrapyramidal symptoms). Neuroleptic-Induced Tardive Dyskinesia, on the other hand, develops during exposure to (or withdrawal from) neuroleptic medication in individuals with a history of neuroleptic use for at least 3 months (or 1 month in middle-age and elderly persons).

Research criteria for 333.82 Neuroleptic-Induced Tardive Dyskinesia

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

B. The involuntary movements are present over a period of at least 4 weeks and occur in any of the following patterns:

   (1) choreiform movements (i.e., rapid, jerky, nonrepetitive)
   (2) athetoid movements (i.e., slow, sinuous, continual)
   (3) rhythmic movements (i.e., stereotypies)

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

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

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

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

333.1 Medication-Induced Postural Tremor

Diagnostic Features

The essential feature of Medication-Induced Postural Tremor is a fine postural tremor that has developed in association with the use of a medication. Medications with

which such a tremor may be associated include lithium, beta-adrenergic medications (e.g., isoproterenol), stimulants (e.g., amphetamine), dopaminergic medications, anticonvulsant medications (e.g., valproic acid), neuroleptic medications, antidepressant medications, and methylxanthines (e.g., caffeine, theophylline). The tremor is a regular, rhythmic oscillation of the limbs (most commonly hands and fingers), head, mouth, or tongue with a frequency of between 8 and 12 cycles per second. It is most easily observed when the affected body part is held in a sustained posture (e.g., hands outstretched, mouth held open). When an individual describes a tremor that is consistent with this definition, but the clinician does not directly observe the tremor, it may be helpful to try to re-create the situation in which the tremor occurred (e.g., drinking from a cup and saucer). The symptoms are not due to a preexisting, nonpharmacologically induced tremor and are not better accounted for by Neuroleptic-Induced Parkinsonism.

Associated Features

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

Differential Diagnosis

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

Medication-Induced Postural Tremor is not diagnosed if the tremor is better accounted for by **Neuroleptic-Induced Parkinsonism.** A Medication-Induced Postural Tremor is usually absent at rest and intensifies when the affected part is brought into

action or held in a sustained position. In contrast, the tremor related to Neuroleptic-Induced Parkinsonism is usually lower in frequency, worse at rest, and suppressed during intentional movement and usually occurs in association with other symptoms of Neuroleptic-Induced Parkinsonism (e.g., akinesia, rigidity).

Research criteria for 333.1 Medication-Induced Postural Tremor

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

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

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

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

333.90 Medication-Induced Movement Disorder Not Otherwise Specified

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

Proposed Axes for Further Study

Defensive Functioning Scale

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

To use the Defensive Functioning Scale, the clinician should list up to seven of the

specific defenses or coping styles (starting with the most prominent) and then indicate the predominant defense level exhibited by the individual. These should reflect the defenses or coping styles employed at the time of evaluation, supplemented by whatever information is available about the individual's defenses or coping patterns during the recent time period that preceded the evaluation. The specific defense mechanisms listed may be drawn from the different Defense Levels.

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

Defense Levels and Individual Defense Mechanisms

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

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

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

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

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

- devaluation
- idealization
- omnipotence

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

- denial
- projection
- rationalization

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

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

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

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

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

- delusional projection
- psychotic denial
- psychotic distortion

Recording Form: Defensive Functioning Scale

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

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

B. Predominant Current Defense Level: _____

Example

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

A. Current Defenses or Coping Styles:

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

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

Glossary of Specific Defense Mechanisms and Coping Styles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

reaction formation The individual deals with emotional conflict or internal or external stressors by substituting behavior, thoughts, or feelings that are diametrically

opposed to his or her own unacceptable thoughts or feelings (this usually occurs in conjunction with their repression).

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

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

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

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

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

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

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

Global Assessment of Relational Functioning (GARF) Scale

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21–40 ***Overall:*** *Relational unit is obviously and seriously dysfunctional; forms and time periods of satisfactory relating are rare.*

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

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

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

1–20 ***Overall:*** *Relational unit has become too dysfunctional to retain continuity of contact and attachment.*

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

Family/couple members are not organized in such a way that personal or generational responsibilities are recognized. Boundaries of relational unit as a

whole and subsystems cannot be identified or agreed on. Family members are physically endangered or injured or sexually attacked.

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

0 Inadequate information.

Social and Occupational Functioning Assessment Scale (SOFAS)

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

Social and Occupational Functioning Assessment Scale (SOFAS)

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

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

100 | 91 Superior functioning in a wide range of activities.

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

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

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

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

50 | 41 Serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

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

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

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

10 | 1 Persistent inability to maintain minimal personal hygiene. Unable to function without harming self or others or without considerable external support (e.g., nursing care and supervision).

0 Inadequate information.

Note: The rating of overall psychological functioning on a scale of 0–100 was operationalized by Luborsky in the Health-Sickness Rating Scale. (Luborsky L: "Clinicians' Judgments of Mental Health." *Archives of General Psychiatry* 7:407–417, 1962). Spitzer and colleagues developed a revision of the Health-Sickness Rating Scale called the Global Assessment Scale (GAS) (Endicott J, Spitzer RL, Fleiss JL, et al.: "The Global Assessment Scale: A Procedure for Measuring Overall Severity of Psychiatric Disturbance." *Archives of General Psychiatry* 33:766–771, 1976). The SOFAS is derived from the GAS and its development is described in Goldman HH, Skodol AE, Lave TR: "Revising Axis V for DSM-IV: A Review of Measures of Social Functioning." *American Journal of Psychiatry* 149:1148–1156, 1992.

Appendix C

Glossary of Technical Terms

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

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

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

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

agonist/antagonist medication A chemical entity extrinsic to endogenously produced substances that acts on a family of receptors (such as mu, delta, and kappa opiate receptors) in such a fashion that it is an agonist or partial agonist on one type of receptor and an antagonist on another.

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

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

amnesia Loss of memory. Types of amnesia include

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

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

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

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

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

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

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

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

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

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

catatonic behavior Marked motor abnormalities including *motoric immobility* (i.e., catalepsy or stupor), certain types of *excessive motor activity* (apparently purposeless

agitation not influenced by external stimuli), *extreme negativism* (apparent motiveless resistance to instructions or attempts to be moved) or *mutism, posturing* or *stereotyped movements*, and *echolalia* or *echopraxia*.

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

defense mechanism Automatic psychological process that protects the individual against anxiety and from awareness of internal or external stressors or dangers. Defense mechanisms mediate the individual's reaction to emotional conflicts and to external stressors. Some defense mechanisms (e.g., projection, splitting, and acting out) are almost invariably maladaptive. Others, such as suppression and denial, may be either maladaptive or adaptive, depending on their severity, their inflexibility, and the context in which they occur. Definitions of specific defense mechanisms and how they would be recorded using the Defensive Functioning Scale are presented on p. 807.

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

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

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

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

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

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

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

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

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

of reference A delusion whose theme is that events, objects, or other persons in one's immediate environment have a particular and unusual significance.

These delusions are usually of a negative or pejorative nature, but also may be grandiose in content. This differs from an *idea of reference*, in which the false belief is not as firmly held nor as fully organized into a true belief.

persecutory A delusion in which the central theme is that one (or someone to whom one is close) is being attacked, harassed, cheated, persecuted, or conspired against.

somatic A delusion whose main content pertains to the appearance or functioning of one's body.

thought broadcasting The delusion that one's thoughts are being broadcast out loud so that they can be perceived by others.

thought insertion The delusion that certain of one's thoughts are not one's own, but rather are inserted into one's mind.

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

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

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

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

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

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

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

dyskinesia Distortion of voluntary movements with involuntary muscular activity.

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

dystonia Disordered tonicity of muscles.

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

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

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

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

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

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

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

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

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

Types of hallucinations include

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

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

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

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

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

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

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

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

hyperacusis Painful sensitivity to sounds.

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

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

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

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

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

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

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

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

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

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

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

Types of mood include

dysphoric An unpleasant mood, such as sadness, anxiety, or irritability.
elevated An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling "high," "ecstatic," "on top of the world," or "up in the clouds."
euthymic Mood in the "normal" range, which implies the absence of depressed or elevated mood.
expansive Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.
irritable Easily annoyed and provoked to anger.

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

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

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

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

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

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

parasomnia Abnormal behavior or physiological events occurring during sleep or sleep-wake transitions.

personality Enduring patterns of perceiving, relating to, and thinking about the environment and oneself. *Personality traits* are prominent aspects of personality that are exhibited in a wide range of important social and personal contexts. Only when personality traits are inflexible and maladaptive and cause either significant functional impairment or subjective distress do they constitute a Personality Disorder.

phobia A persistent, irrational fear of a specific object, activity, or situation (the phobic stimulus) that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.

pressured speech Speech that is increased in amount, accelerated, and difficult or impossible to interrupt. Usually it is also loud and emphatic. Frequently the person talks without any social stimulation and may continue to talk even though no one is listening.

prodrome An early or premonitory sign or symptom of a disorder.

psychomotor agitation *See* agitation.

psychomotor retardation Visible generalized slowing of movements and speech.

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

residual phase The phase of an illness that occurs after remission of the florid symptoms or the full syndrome.

sex A person's biological status as male, female, or uncertain. Depending on the circumstances, this determination may be based on the appearance of the external genitalia or on karyotyping.

sign An objective manifestation of a pathological condition. Signs are observed by the examiner rather than reported by the affected individual.

stereotyped movements Repetitive, seemingly driven, and nonfunctional motor behavior (e.g., hand shaking or waving, body rocking, head banging, mouthing of objects, self-biting, picking at skin or body orifices, hitting one's own body).

stressor, psychosocial Any life event or life change that may be associated temporally (and perhaps causally) with the onset, occurrence, or exacerbation of a mental disorder.

stupor A state of unresponsiveness with immobility and mutism.

symptom A subjective manifestation of a pathological condition. Symptoms are reported by the affected individual rather than observed by the examiner.

syndrome A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

synesthesia A condition in which a sensory experience associated with one modality occurs when another modality is stimulated, for example, a sound produces the sensation of a particular color.

tic An involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped motor movement or vocalization.

transsexualism Severe gender dysphoria, coupled with a persistent desire for the physical characteristics and social roles that connote the opposite biological sex.

Appendix D

Highlights of Changes in DSM-IV Text Revision

This appendix provides an overview of the changes made to the text. It should be noted that the following is not an exhaustive guide—changes in wording made for clarity and expansions of the differential diagnosis sections of the text are not included here. It should also be noted that the majority of paragraphs in DSM-IV have not been revised, indicating that, even after the literature review, most of the information in the original text remains up-to-date.

Introduction. Several paragraphs have been added describing the DSM-IV text revision process, and additional clarifying text has been added to the Use of Clinical Judgment section regarding the importance of the method of data collection in determining whether diagnostic criteria have been met.

Multiaxial assessment. The instructions for making a Global Assessment of Functioning (GAF) rating have been greatly expanded. Discussions about applying the GAF to the current time frame and about the underlying structure of the scale (i.e., each element's having a symptom and functioning component) have been added. Finally, a four-step method to ensure that no elements of the GAF scale are overlooked when making a GAF rating is provided.

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Mental Retardation. Additional information has been added regarding the association of certain etiological factors and comorbid symptoms and disorders (e.g., fragile X syndrome and Attention-Deficit/Hyperactivity Disorder).

Communication Disorders. Text has been added to indicate that a thorough functional assessment of the individual's language ability can be made when standardized tests are unavailable or inappropriate (e.g., because the available tests were standardized only in limited populations). Prevalence and Course sections for Expressive Language Disorder, Mixed Receptive-Expressive Language Disorder, and Phonological Disorder, as well as the Course section for Stuttering, have been updated.

Autistic Disorder. The text in the Diagnostic Features section has been modified to highlight difficulties in the pragmatic aspects of language, which are especially relevant in the assessment of higher-functioning individuals. In addition, better examples of restricted, repetitive, and stereotyped patterns of behavior, interests, and activities have been added. The text has also been modified to reflect evidence that in up to one-fifth of cases, parents retrospectively report relatively normal development for the first 1 or 2 years. The section on associated cognitive deficits and associated general medical conditions has been updated. The range of prevalence figures has been revised to reflect a number of more recent studies that suggest a higher prevalence. More specific information regarding sibling risk has been added to the Familial Pattern section.

Rett's Disorder. Text has been added reflecting the finding that some cases of Rett's Disorder are associated with a specific genetic mutation.

Asperger's Disorder. Because of the limited data available about this newly introduced disorder, the DSM-IV text for Asperger's Disorder provided little more than a restatement of the diagnostic criteria. Accordingly, the text for Asperger's Disorder has now been extensively revised. Specific examples of the typical manifestations of the impairment in reciprocal social interaction and in restricted, repetitive behavior and interests are provided in order to better differentiate these individuals from those with Autistic Disorder. In addition, text has been added to clarify that the requirement for no clinically significant delays in language does not imply that individuals with Asperger's Disorder have no problems with communication. The Associated Features and Disorders, Course, and Differential Diagnosis sections have been greatly expanded and a section on Specific Age Features has been added.

Pervasive Developmental Disorder Not Otherwise Specified. The definition has been changed to correct an error that inadvertently allowed this diagnosis to be made in cases in which there was a pervasive impairment in only one developmental area (i.e., in the development of reciprocal social interaction, communication skills, or stereotyped behaviors, interests, or activities). The definition now requires that there be impairment in reciprocal social interaction that is associated with an impairment in communication skills or with the presence of stereotyped behaviors, interests, or activities.

Attention-Deficit/Hyperactivity Disorder. Many of the changes highlight differences among the subtypes. For example, individuals with the Predominantly Inattentive and Combined Types tend to have academic deficits and school-related problems, whereas those with the Predominantly Hyperactive-Impulsive Type tend to have more peer rejection and accidental injuries. Gender ratio is less predominantly male in the Predominantly Inattentive Type. Additional information about Associated Features (e.g., variability in IQ, presence of family discord) and Specific Age Features (especially Attention-Deficit/Hyperactivity Disorder in adults) is included. Estimates of prevalence rates have been revised upward, reflecting increased prevalence due to the inclusion of the Predominantly Hyperactive-Impulsive and Predominantly Inattentive Types in DSM-IV.

Conduct Disorder. The list of risk factors for developing Conduct Disorder has been expanded. The relationship between Oppositional Defiant Disorder and the subsequent development of the Childhood-Onset Type of Conduct Disorder has been noted in the Course section.

Oppositional Defiant Disorder. The Course section of the text clarifies that although Childhood-Onset cases of Conduct Disorder are often preceded by Oppositional Defiant Disorder, many children with Oppositional Defiant Disorder do not go on to develop Conduct Disorder.

Pica. Prevalence data have been provided, and comorbidity with Pervasive Developmental Disorders is noted.

Feeding Disorder of Infancy or Early Childhood. Changes have been made in the Prevalence (community prevalence is noted) and Course sections (persistence of decreased height and weight into adolescence compared with peers).

Tic Disorders. The DSM-IV criteria set for Tic Disorders has been corrected by eliminating the requirement for "clinically significant distress or impairment" that was added to the majority of disorders in DSM-IV (Tic Disorders among them). This criterion has been problematic in Tic Disorders for a number of reasons, including the fact that it is at variance with clinical experience (i.e., most children with Tourette's Disorder do not experience marked distress or impairment) and that it hinders epidemiological research and family studies. Other changes in the text include an expanded description of the types of tics as well as an expansion of the Differential Diagnosis section (i.e., differentiating between tics and other types of movements) and of the Associated Features and Disorders (including comorbidity patterns), Specific Age Features (gender ratio), Prevalence, Course, and Familial Pattern sections of Tourette's Disorder.

Encopresis. Encopresis with functional constipation is the most common form. Text regarding physiological predispositions to constipation has been updated and expanded.

Enuresis. New information about different mechanisms underlying the Diurnal Only Type has been added. Associated Features and Disorders (particularly predisposing factors), Prevalence, and Familial Pattern sections have been updated.

Separation Anxiety Disorder. The Prevalence and Course sections have been updated to indicate that there is a decrease in prevalence from childhood through adolescence and that most children with separation anxiety are free of an impairing Anxiety Disorder at extended follow-up.

Reactive Attachment Disorder. The Associated Features and Disorders (risk factors such as extreme neglect and institutional care) and Course (persistence of indiscriminant sociability) sections have been updated.

Stereotypic Movement Disorder. Pathological skin picking has been removed from the list of examples—such cases should be diagnosed as Impulse-Control Disorder Not Otherwise Specified. The Associated Features and Disorders section (i.e., clarification that the disorder can occur in non–developmentally delayed populations) has been modified.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders

Delirium. The Associated Features and Disorders section has been modified to emphasize the presence of two varieties of delirium: hyperactive and hypoactive. Text has also been added to the Specific Culture, Age, and Gender Features section to reflect the finding that advanced age has been found to be a risk factor for delirium in a variety of study populations, even after other risk factors (such as concomitant illness) are controlled for. Prevalence data on delirium in a variety of medically ill populations are now available (e.g., up to 60% of nursing home residents age 75 or older may develop delirium). The importance of early recognition and treatment of delirium is highlighted in the substantial additions to the Course section of the text (e.g., individuals with better premorbid cognitive and physical functioning have a better recovery).

Delirium Due to a General Medical Condition. The list of associated general medical conditions has been reorganized and updated.

Substance-Induced Delirium. Text has been added to clarify that the onset and offset may be affected by various factors such as brain damage, older age, substance half-life, presence of multiple substances, and poor clearance.

Dementia. There are new diagnostic codes for the dementias (with the exception of that for Vascular Dementia, which remains unchanged). The code for all types of dementia (except Vascular) is 294.10 if the subtype is "Without Behavioral Disturbance," and 294.11 if the subtype is "With Behavioral Disturbance." Codable subtypes that previously applied to Dementia of the Alzheimer's Type (e.g., With Depressed Mood) no longer apply. Instead, the corresponding Mental Disorder Due to a General Medical Condition (e.g., 293.83 Mood Disorder Due to Alzheimer's Disease) should be coded on Axis I. Because of ICD-9-CM coding conventions, Vascular Dementia codes and subtypes remained unchanged.

The list of causes of dementia has been updated to reflect that the most common cause, after Alzheimer's disease, is another neurodegenerative process, such as Lewy body disease or frontotemporal degeneration—two etiologies that are not specifically listed in DSM-IV. Prevalence figures have been updated to reflect more recent epidemiological data (i.e., around 1.5% for individuals ages 65–69 years, rising to 16%–25% for those over age 85 years).

Dementia of the Alzheimer's Type. Although an enormous effort has gone into the development of biological markers for Alzheimer's disease, none of these markers are

as yet widely accepted. Text has been added to the Associated Laboratory Findings subsection (as well as the Differential Diagnosis section for Dementia) acknowledging that Alzheimer's disease remains a diagnosis of exclusion. The section on Course has been updated to highlight the development of personality changes. Prevalence estimates have been revised on the basis of the United States General Accounting Office's 1998 report on the prevalence of Alzheimer's disease. Finally, the Familial Pattern section has been updated to reflect current data on chromosomal linkage and the role of the genetic marker *APOE4* as a risk factor for the development of late-onset cases.

Dementia Due to Parkinson's Disease/Dementia Due to Pick's Disease. Two of the most common forms of dementia are Lewy body dementia (an example of which is Dementia Due to Parkinson's Disease) and frontotemporal dementia (of which Dementia Due to Pick's Disease is an example). Although there was insufficient evidence to justify a radical reorganization of this section, text has been added to the sections on Dementia Due to Other General Medical Conditions, Dementia Due to Parkinson's Disease, and Dementia Due to Pick's Disease to clarify how such cases should be classified.

Dementia Due to Creutzfeldt-Jakob Disease. Text has been added regarding the cross-species transmission of prion infections, reflecting the outbreak of a human variant of bovine spongiform encephalopathy in the United Kingdom in the mid-1990s.

Mental Disorders Due to a General Medical Condition

Personality Change Due to a General Medical Condition. A change has been made to correct an error in the exclusion criterion, which does not allow a diagnosis of Personality Change Due to a General Medical Condition to be given comorbidly with a diagnosis of dementia. This criterion was an unintended carryover from DSM-III-R, which excluded personality change in the presence of dementia because personality change was included in the diagnostic criteria for dementia. Clinically significant symptoms occurring with dementia are diagnosed by coding the specific mental disorder due to a general medical condition on Axis I alongside the dementia. Thus, this exclusion has been removed, allowing, for example, an individual with Alzheimer's disease who develops a change in personality to be given a comorbid diagnosis of Personality Change Due to Alzheimer's Disease.

Substance-Related Disorders

Substance Dependence. The Features section has been updated to indicate that varied degrees of tolerance may develop to the different central nervous system effects of a substance, that tolerance may develop to phencyclidine, and that a past history of tolerance or withdrawal is associated with a worse clinical course (i.e., earlier onset, higher levels of substance intake, and greater numbers of substance-related problems).

Familial Pattern sections for Dependence/Abuse/Intoxication/Withdrawal. The text has been updated to clarify that individuals who may be at higher risk for Alcohol Dependence because of a family history of Alcohol Dependence do not necessarily have a higher risk of developing Dependence on other substances.

Substance-Induced Disorders. Examples have been added to help clarify when it is appropriate to diagnose Substance Intoxication or Substance Withdrawal versus a Substance-Induced Disorder With Onset During Intoxication or With Onset During Withdrawal.

Alcohol-Related Disorders. The Associated Features and Disorders section (e.g., risk of alcohol-related accidents, comorbidity with other disorders) has been updated. A discussion of the laboratory test carbohydrate deficient transferrin (CDT), a widely used state marker for heavy drinking, has been added. In the Specific Culture, Age, and Gender Features section, the text concerning the low rates of Dependence in Asians and the clinical course in women has been expanded. Text regarding the prevalence of alcohol use, alcohol-related complications, and Alcohol Dependence has been expanded and updated.

Amphetamine (or Amphetamine-Like)–Related Disorders. Text regarding the prevalence of amphetamine use across different age groups and the prevalence of Dependence has been expanded and updated.

Caffeine-Related Disorders. The Specific Culture, Age, and Gender Features section has been expanded to include information about the increased sensitivity of the elderly to the effects of caffeine. A Prevalence section has been added that describes patterns of caffeine use, and the Course section has been expanded and updated.

Cannabis-Related Disorders. Updated information regarding mechanisms of action has been added to the introductory section. The text for Cannabis Dependence has been updated to clarify that evidence of physiological dependence is seen in chronic users and may be associated with more severe cannabis-related problems. Text regarding the prevalence of cannabis use across different age groups and the prevalence of Dependence has been expanded and updated. A discussion of whether cannabis use is a precursor to other drug use (i.e., its role as a "gateway drug") has been added to the Course section.

Cocaine-Related Disorders. The complications of severe Cocaine Intoxication have been updated and expanded, and the Specific Culture, Age, and Gender Features section has also been updated. Text regarding the prevalence of cocaine use across different age groups and the prevalence of Dependence and Abuse has been expanded and updated.

Hallucinogen-Related Disorders. A discussion of the physiological changes associated with intoxication (e.g., increases in blood glucose) has been added. Text regarding the prevalence of hallucinogen use across different age groups and the prevalence of Dependence and Abuse has been expanded and updated.

Inhalant-Related Disorders. Additional information has been added to the subsections on Associated Laboratory Findings (i.e., the availability of urine assay for a metabolite of toluene) and Associated Physical Examination Findings and General Medical Conditions (i.e., an expanded list of respiratory complications and discussion of a possible association between benzene and acute myelocytic leukemia). Text regarding the prevalence of different types of inhalant use among different age and other demographic groups has been added.

Nicotine-Related Disorders. The Specific Culture, Age, and Gender Features section has been updated (e.g., data about increased nicotine blood levels in African Americans have been added). Text regarding the prevalence of smoking and other tobacco use in various groups and the prevalence of Nicotine Dependence has been updated. The Course section has also been revised on the basis of new data.

Opioid-Related Disorders. Text regarding hepatitis screening tests has been added to the Associated Laboratory Findings subsection, and death rates from medical complications have been added to the Associated Physical Examination Findings and General Medical Conditions subsection. The Specific Culture, Age, and Gender Features (i.e., gender ratio) and Course (i.e., remission rates) sections have been updated. Text regarding the prevalence of different patterns of opioid use among different age and other demographic groups has been updated and expanded.

Phencyclidine (or Phencyclidine-Like)–Related Disorders. Text regarding the prevalence of different patterns of phencyclidine use among different age groups has been updated and expanded.

Sedative-, Hypnotic-, and Anxiolytic-Related Disorders. Text regarding patterns of use among different age groups and the prevalence of Dependence and Abuse has been updated.

Polysubstance Dependence. Examples have been added to clarify the appropriate use of this category.

Schizophrenia and Other Psychotic Disorders

The introduction has been updated to emphasize that psychotic symptoms are not necessarily considered to be core features of the disorders included in this section, nor do the disorders in this section necessarily have a common etiology.

Schizophrenia. The Associated Features and Disorders section has been updated and expanded to include additional information on anosognosia (lack of insight), risk factors for suicidal and violent behavior, and comorbidity with other mental disorders. The Associated Laboratory Findings subsection has also been updated to include separate discussions of structural and functional neuroimaging, neuropsychological deficits, and neurophysiological abnormalities. The Specific Culture, Age, and Gender Features section includes an expanded discussion about overdiagnosis of Schizophrenia in certain racial groups, updated information regarding late-onset

cases, and updated text regarding gender differences. The Prevalence section has been updated to include additional information and geographic and historical variations in incidence. The Familial Pattern section introduces the concept of "schizophrenia spectrum" (i.e., the range of disorders that are more likely in the relatives of individuals with Schizophrenia).

Schizophrenia Subtypes. The introduction has been updated to indicate limited stability and prognostic value of the subtypes.

Schizophreniform Disorder. Updated prevalence information has been provided, including contrasting rates in developed and developing countries. A brief Familial Pattern section has been added, indicating a possible increased risk of Schizophrenia in relatives of individuals with Schizophreniform Disorder.

Schizoaffective Disorder. The Specific Culture, Age, and Gender Features (i.e., elevated rates in women are mostly accounted for by increased incidence of the Depressive Type) and Course (i.e., association of stressors with a better prognosis) sections have been updated.

Delusional Disorder. The Course section has been updated.

Brief Psychotic Disorder. The Prevalence section has been updated to note that although this disorder is rarely seen in developed countries, psychotic episodes o slightly longer duration (1–6 months) are more common in developing countries.

Psychotic Disorder Due to a General Medical Condition. The list of etiological general medical conditions has been updated, and sections on Prevalence and Course have been added.

Mood Disorders

Major Depressive Episode. The Associated Laboratory Findings subsection of the text has been updated and expanded to include additional neurobiological abnormalities (e.g., alterations in neuropeptides and other hormones in response to challenge tests) and functional brain imaging results. The Specific Culture, Age, and Gender Features section has been updated to clarify that increased risk in women emerges during adolescence and may coincide with puberty.

Major Depressive Disorder. The Associated Physical Examination Findings and General Medical Conditions subsection has been updated to emphasize that comorbid general medical conditions worsen the course of Major Depressive Disorder. The Specific Culture, Age, and Gender Features section has been expanded to include information about laboratory findings (e.g., evidence of subcortical white matter hyperintensities) in late-onset depression. Changes in the Familial Pattern section indicate increased risk of Anxiety Disorders in offspring of individuals with depression.

Dysthymic Disorder. The Course section has been updated to indicate that the outcome of Dysthymic Disorder is significantly better with active treatment. Changes to

the Familial Pattern section indicate elevated rates of both Dysthymic Disorder and Major Depressive Disorder in relatives of those with Dysthymic Disorder.

Bipolar I Disorder and Bipolar II Disorder. The Associated Descriptive Features and Mental Disorders subsection has been expanded to include information on the comorbidity of Bipolar I Disorder and Alcohol and other Substance Use Disorders. The Associated Laboratory Findings subsection has been updated to reflect increased rates of certain brain lesions in individuals with Bipolar I Disorder as a group. The Associated Physical Examination Findings and General Medical Conditions subsection has been expanded to clarify the relationship between Bipolar I and Bipolar II Disorders and thyroid dysfunction (i.e., association between hypofunction and rapid cycling, and hyperthyroidism precipitating episodes in those with preexisting Mood Disorder). The Specific Culture, Age, and Gender Features section has been updated to reflect gender differences in Rapid Cycling, types of episodes, and risk for mixed episodes. The relationship between age at onset and family history is noted in the Familial Pattern section of Bipolar I Disorder.

Bipolar Disorder Not Otherwise Specified. An additional example has been added to clarify that individuals with chronic dysthymia who also experience occasional hypomanic episodes do not qualify for a diagnosis of either Dysthymic Disorder (because hypomanic episodes are present) or Cyclothymic Disorder (because the hypomanic episodes are too infrequent).

Catatonic Features. The text has been expanded to provide a breakdown of the causes of catatonia.

Melancholic Features. The original statement that individuals with Melancholic Features are more likely to respond to somatic treatment is incorrect and has been replaced by text that emphasizes the need for active treatment given the low placebo response rate.

Atypical Features. Text has been added to clarify that, when used to describe the most recent (as opposed to current) episode, this specifier applies if the features predominate during any 2-week period. In addition, it is noted that individuals with these features are more likely to respond to treatment with monoamine oxidase inhibitors than to tricyclic antidepressants.

Postpartum Onset. The text on associated features has been updated, and text has been added to highlight the differentiation of this subtype from "baby blues."

Rapid Cycling. Updated text includes prevalence data and the potential association between cycling rate and antidepressant therapy.

Anxiety Disorders

Panic Attack. The text describing the three types of Panic Attacks (i.e., unexpected, situationally bound, and situationally predisposed) has been updated to clarify the

nature of the triggers, the association between the types of Panic Attacks and particular Anxiety Disorders, and differential diagnosis.

Panic Disorder. Information about the relationship between Panic Attacks and potential triggers in Panic Disorder has been updated (i.e., situational triggers may be either external or internal, and "unexpected" means that the individual does not immediately associate the attack with a situational trigger). The list of associated general medical conditions has been extended, the Prevalence section has been expanded to include rates in clinical samples, and the Familial Pattern section has been updated to include information from more recent studies (e.g., relationship between age at onset of proband and risk in first-degree relatives). Finally, the Differential Diagnosis section has been expanded to include situations in which the person may not be able to identify the cues triggering a Panic Attack (e.g., cognitions or physiological symptoms similar to those that occurred at the time of the traumatic event in Posttraumatic Stress Disorder).

Specific Phobia. Additional information regarding comorbidity, relative frequency of subtypes in community settings, gender ratio, course (e.g., having Specific Phobia in adolescence increases the chance of having Specific Phobia in adulthood but not other mental disorders), and familial pattern has been provided.

Social Phobia. The Associated Descriptive Features and Mental Disorders section has been updated (i.e., association with suicidal ideation and other Anxiety Disorders). The Associated Laboratory Findings subsection has been updated to clarify that no laboratory test has been found to be diagnostic of Social Phobia (i.e., original text suggesting a differential response to lactate infusion has been deleted).

Obsessive-Compulsive Disorder. Information regarding comorbidity with other mental disorders has been updated. The Specific Culture, Age, and Gender Features section has been updated to include a brief section on the subset of children who develop Obsessive-Compulsive Disorder in association with Group A beta-hemolytic streptococcal infections. Additional information has been added to draw on the increased body of data regarding children with Obsessive-Compulsive Disorder (e.g., comorbid disorders, prevalence). The Prevalence section has been updated and expanded to include rates in children.

Posttraumatic Stress Disorder. Information regarding associated features, comorbidity with other mental disorders, associations with general medical conditions, prevalence rates, and course (e.g., symptom reactivation in response to reminders of trauma, life stressors, or new traumatic events) has been updated. A brief Familial Pattern section has been added, describing evidence of a heritable component to the transmission of Posttraumatic Stress Disorder and the relationship between a history of depression in first-degree relatives and increased vulnerability to developing Posttraumatic Stress Disorder.

Acute Stress Disorder. Additional information regarding progression to Posttraumatic Stress Disorder and a range of prevalence rates in individuals exposed to severe traumas have been provided.

Generalized Anxiety Disorder. Prevalence in clinical settings and familial pattern (i.e., evidence from twin studies that suggests a genetic contribution) have been updated.

Somatoform Disorders

Somatization Disorder. The Associated Physical Examination Findings and General Medical Conditions subsection has been updated to clarify that some individuals with Somatization Disorder also have objective signs that are part of a comorbid general medical condition.

Conversion Disorder. The Prevalence section has been expanded to include rates in certain general medical settings.

Pain Disorder. The discussion on the risk of iatrogenic Substance Dependence in the Associated Features and Disorders section has been updated and expanded to include factors that minimize the likelihood of developing iatrogenic Substance Dependence. In addition, text on associated sleep problems has been expanded. Text addressing the prevalence of Pain Disorder in clinical settings, as well as additional information about course, has been included.

Hypochondriasis. The Associated Features and Disorders, Prevalence, and Course (i.e., factors associated with better prognosis) sections have been updated.

Body Dysmorphic Disorder. Body build and muscularity have been added to the list of body site preoccupations. The Associated Features and Disorders section has been updated to include additional information about lack of insight and efforts to correct or hide the defects. Reported prevalence rates in clinical settings are also included.

Factitious Disorders

Factitious Disorder. The revised text for the Predominantly Physical Signs and Symptoms subtype more clearly differentiates Münchausen's syndrome (the most severe and chronic form of Factitious Disorder) from less severe, more transient forms. A Specific Gender Features section has been added, and the Prevalence and Course sections have been updated.

Dissociative Disorders

Dissociative Identity Disorder. The text has been modified to indicate that cases of Dissociative Identity Disorder have been documented in a variety of cultures around the world.

Depersonalization Disorder. The Associated Features and Disorders and Course sections have been updated.

Sexual and Gender Identity Disorders

Introductory text has been added to clarify the definitions of the terms *gender identity, gender dysphoria,* and *sexual orientation.*

Sexual Dysfunctions. An Associated Disorders section has been added, and the Prevalence section has been expanded and updated.

Paraphilias. The clinical significance criteria were revised to clarify that for Pedophilia, Voyeurism, Exhibitionism, and Frotteurism, if the person has acted on these urges, or the urges or sexual fantasies cause marked distress or interpersonal difficulty, then by definition there is clinical significance. For Sexual Sadism, if the person has acted on these urges with a nonconsenting person, or the urges, sexual fantasies, or behaviors cause marked distress or interpersonal difficulty, then the clinical significance criterion is met. For the remaining Paraphilias, the clinical significance criterion is met if the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Of course, for the specific diagnosis to be assigned, the particular pattern of paraphilic arousal must also be present.

Gender Identity Disorder. Additional information is included to clarify how the subtypes (based on sexual attraction) differ in terms of associated features and course.

Eating Disorders

Anorexia Nervosa. The Associated Features and Disorders section has been updated to include comorbidity with Personality Disorders. The Prevalence section has been expanded to include figures for males. Course features have been updated to clarify the relationship between Anorexia Nervosa and Bulimia Nervosa.

Bulimia Nervosa. Course section has been updated to include some information on the long-term outcome of Bulimia Nervosa.

Sleep Disorders

Primary Insomnia. The Associated Descriptive Features and Mental Disorders subsection (e.g., functional impairment) and Associated Laboratory Findings subsection (e.g., lack of daytime sleepiness as measured by Multiple Sleep Latency Test [MSLT], substantial discrepancies between subjective report and polysomnographic measures of sleep quality) have been revised. The Specific Age and Gender Features (e.g., in the elderly), Prevalence (e.g., rates of the disorder in the general population), Course (text on chronicity), and Familial Pattern sections have also been updated.

Primary Hypersomnia. The Specific Age and Gender Features (e.g., in children), Prevalence, and Course sections have been updated.

Narcolepsy. Text has bee
gogic and hypnopompic
with normal sleep. The As
section and Course (age
updated. A Specific Age F
agnosis of Narcolepsy in c

Breathing-Related Sleep
ciated Physical Examinati
tion between neck size an
Age and Gender Features

Circadian Rhythm Sleep
been provided in the Asso
tory Findings and Associa
Conditions subsections, a
Pattern sections.

Dyssomnia Not Otherwi
legs syndrome and period
included in the Internatio

Nightmare Disorder. T
subsection (i.e., an associ
symptom measures of oth
quent nightmares in youn

Sleepwalking Disorder.
Specific Culture, Age, and
sections have been updat

Sleep Disorders Related
Features subsection has b

Im
N

Intermittent Explosive
saultive acts include verb
sociated Features and Di
and Mental Disorders sub
gressive acts, such as ti
Course sections have bee
cating those disorders th
individuals with Intermit
tion.

Narcolepsy. Text has been added to clarify that some of the symptoms (i.e., hypnagogic and hypnopompic hallucinations and sleep paralysis) also occur in persons with normal sleep. The Associated Laboratory Findings (including HLA typing) subsection and Course (age at onset vs. age at presentation) section have also been updated. A Specific Age Features section has been added to address issues in the diagnosis of Narcolepsy in children.

Breathing-Related Sleep Disorder. The Associated Laboratory Findings and Associated Physical Examination Findings and General Medical Conditions (i.e., association between neck size and risk for obstructive sleep apnea) subsections and Specific Age and Gender Features (i.e., in children) section have been updated.

Circadian Rhythm Sleep Disorder. Additional subtype-specific information has been provided in the Associated Features and Disorders section, Associated Laboratory Findings and Associated Physical Examination Findings and General Medical Conditions subsections, and Specific Age Features, Prevalence, Course, and Familial Pattern sections.

Dyssomnia Not Otherwise Specified. Greatly expanded descriptions of restless legs syndrome and periodic limb movements, two well-established Sleep Disorders included in the International Classification of Sleep Disorders, are now included.

Nightmare Disorder. The Associated Descriptive Features and Mental Disorders subsection (i.e., an association between frequent chronic nightmares and increased symptom measures of other psychopathology) and the Prevalence (i.e., rates of frequent nightmares in young adults) and Course sections have been updated.

Sleepwalking Disorder. The Associated Laboratory Findings subsection and the Specific Culture, Age, and Gender Features, Prevalence, Course, and Familial Pattern sections have been updated.

Sleep Disorders Related to Another Mental Disorder. The Associated Laboratory Features subsection has been updated.

Impulse-Control Disorders Not Elsewhere Classified

Intermittent Explosive Disorder. Text has been added clarifying that serious assaultive acts include verbal threats of physical assault to another individual. The Associated Features and Disorders—in particular the Associated Descriptive Features and Mental Disorders subsection (e.g., symptoms that precede or accompany the aggressive acts, such as tingling or tremors, as well as accompanying affect)—and Course sections have been updated. A Familial Pattern section has been added, indicating those disorders that may be more common among first-degree relatives of individuals with Intermittent Explosive Disorder compared with the general population.

Kleptomania. The Associated Features and Disorders and Familial Pattern (i.e., possible family history of Obsessive-Compulsive Disorder in first-degree relatives of individuals with Kleptomania) sections have been updated. A Specific Gender Features section (i.e., gender ratio) has also been added.

Pathological Gambling. An Associated Laboratory Findings subsection (e.g., a variety of abnormalities reported in samples of males) has been added. The Associated Features and Disorders (e.g., childhood history of inattentive or hyperactive symptoms) and Prevalence (e.g., influence of availability of legalized gambling on the prevalence of Pathological Gambling) sections have been updated.

Trichotillomania. The Associated Features and Disorders, Prevalence, and Course sections have been updated.

Adjustment Disorders

The Associated Features and Disorders section has been updated to clarify comorbidity with other disorders. The Prevalence section has been expanded to include rates in children and in particular clinical settings. The Course section now includes text about the risk of progression to other disorders.

Personality Disorders

Introductory Text for Personality Disorders. The text describing dimensional models has been updated, presenting the dimensions in terms of some of the more important models.

Antisocial Personality Disorder. The Associated Features and Disorders text has been updated to clarify that features that are part of the traditional conception of psychopathy may be more predictive of recidivism in settings (e.g., prisons) where criminal acts are likely to be nonspecific.

Borderline Personality Disorder. Text has been added to the Course section to emphasize that, contrary to many clinicians' preconceived notions, the prognosis for many individuals with Borderline Personality Disorder is good.

Dependent Personality Disorder. The text for the Specific Culture, Age, and Gender Features section has been changed to remove the suggestions that reported gender difference is largely artifactual.

Obsessive-Compulsive Personality Disorder. The Associated Features and Disorders section has been updated to further clarify the relationship between Anxiety Disorders (especially Obsessive-Compulsive Disorder) and Obsessive-Compulsive Personality Disorder.

Changes have been mac
made in the descriptive t
postpsychotic depressive
der, mixed anxiety-depr
Movement Disorders sec
pendixes E, F, and G hav
have taken place over the
DSM-IV Text Revision ac

Appendixes

Changes have been made to several of the appendixes. Small changes have been made in the descriptive text for some of the research categories in Appendix B (e.g., postpsychotic depressive disorder of Schizophrenia, premenstrual dysphoric disorder, mixed anxiety-depressive disorder), and the text for the Medication-Induced Movement Disorders section has been updated to include atypical neuroleptics. Appendixes E, F, and G have been updated to correct for ICD-9-CM coding changes that have taken place over the past several years. Appendix K, containing the names of the DSM-IV Text Revision advisers, has also been added.

Appendix E

Alphabetical Listing of DSM-IV-TR Diagnoses and Codes

NOS = Not Otherwise Specified.

V62.3	Academic Problem
V62.4	Acculturation Problem
308.3	Acute Stress Disorder
	Adjustment Disorders
309.9	Unspecified
309.24	With Anxiety
309.0	With Depressed Mood
309.3	With Disturbance of Conduct
309.28	With Mixed Anxiety and Depressed Mood
309.4	With Mixed Disturbance of Emotions and Conduct
V71.01	Adult Antisocial Behavior
995.2	Adverse Effects of Medication NOS
780.9	Age-Related Cognitive Decline
300.22	Agoraphobia Without History of Panic Disorder
	Alcohol
305.00	Abuse
303.90	Dependence
291.89	-Induced Anxiety Disorder
291.89	-Induced Mood Disorder
291.1	-Induced Persisting Amnestic Disorder
291.2	-Induced Persisting Dementia
	-Induced Psychotic Disorder
291.5	With Delusions
291.3	With Hallucinations
291.89	-Induced Sexual Dysfunction
291.89	-Induced Sleep Disorder
303.00	Intoxication
291.0	Intoxication Delirium
291.9	-Related Disorder NOS
291.81	Withdrawal
291.0	Withdrawal Delirium
294.0	Amnestic Disorder Due to . . . *[Indicate the General Medical Condition]*

294.8	Amnestic Disorder NOS
	Amphetamine (or Amphetamine-Like)
305.70	Abuse
304.40	Dependence
292.89	-Induced Anxiety Disorder
292.84	-Induced Mood Disorder
	-Induced Psychotic Disorder
292.11	With Delusions
292.12	With Hallucinations
292.89	-Induced Sexual Dysfunction
292.89	-Induced Sleep Disorder
292.89	Intoxication
292.81	Intoxication Delirium
292.9	-Related Disorder NOS
292.0	Withdrawal
307.1	Anorexia Nervosa
301.7	Antisocial Personality Disorder
293.84	Anxiety Disorder Due to . . . *[Indicate the General Medical Condition]*
300.00	Anxiety Disorder NOS
299.80	Asperger's Disorder
	Attention-Deficit/Hyperactivity Disorder
314.01	Combined Type
314.01	Predominantly Hyperactive-Impulsive Type
314.00	Predominantly Inattentive Type
314.9	Attention-Deficit/Hyperactivity Disorder NOS
299.00	Autistic Disorder
301.82	Avoidant Personality Disorder
V62.82	Bereavement
296.80	Bipolar Disorder NOS
	Bipolar I Disorder, Most Recent Episode Depressed
296.56	In Full Remission
296.55	In Partial Remission
296.51	Mild
296.52	Moderate
296.53	Severe Without Psychotic Features
296.54	Severe With Psychotic Features
296.50	Unspecified
296.40	Bipolar I Disorder, Most Recent Episode Hypomanic
	Bipolar I Disorder, Most Recent Episode Manic
296.46	In Full Remission
296.45	In Partial Remission
296.41	Mild
296.42	Moderate
296.43	Severe Without Psychotic Features
296.44	Severe With Psychotic Features
296.40	Unspecified

Bipolar I Disorder, Most Recent Episode Mixed
296.66 In Full Remission
296.65 In Partial Remission
296.61 Mild
296.62 Moderate
296.63 Severe Without Psychotic Features
296.64 Severe With Psychotic Features
296.60 Unspecified
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
Bipolar I Disorder, Single Manic Episode
296.06 In Full Remission
296.05 In Partial Remission
296.01 Mild
296.02 Moderate
296.03 Severe Without Psychotic Features
296.04 Severe With Psychotic Features
296.00 Unspecified
296.89 Bipolar II Disorder
300.7 Body Dysmorphic Disorder
V62.89 Borderline Intellectual Functioning
301.83 Borderline Personality Disorder
780.59 Breathing-Related Sleep Disorder
298.8 Brief Psychotic Disorder
307.51 Bulimia Nervosa
Caffeine
292.89 -Induced Anxiety Disorder
292.89 -Induced Sleep Disorder
305.90 Intoxication
292.9 -Related Disorder NOS
Cannabis
305.20 Abuse
304.30 Dependence
292.89 -Induced Anxiety Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
293.89 Catatonic Disorder Due to . . . *[Indicate the General Medical Condition]*
299.10 Childhood Disintegrative Disorder
V71.02 Child or Adolescent Antisocial Behavior
307.22 Chronic Motor or Vocal Tic Disorder
307.45 Circadian Rhythm Sleep Disorder
Cocaine
305.60 Abuse
304.20 Dependence

292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
292.0 Withdrawal
294.9 Cognitive Disorder NOS
307.9 Communication Disorder NOS
Conduct Disorder
312.81 Childhood-Onset Type
312.82 Adolescent-Onset Type
312.89 Unspecified Type
300.11 Conversion Disorder
301.13 Cyclothymic Disorder
293.0 Delirium Due to . . . *[Indicate the General Medical Condition]*
780.09 Delirium NOS
297.1 Delusional Disorder
Dementia Due to Creutzfeldt-Jakob Disease
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to Head Trauma
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to HIV Disease
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to Huntington's Disease
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to Parkinson's Disease
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to Pick's Disease
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia Due to . . . *[Indicate Other General Medical Condition]*
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
294.8 Dementia NOS

*ICD-9-CM code valid after October 1, 2000.

Dementia of the Alzheimer's Type, With Early Onset
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
Dementia of the Alzheimer's Type, With Late Onset
294.10* Without Behavioral Disturbance
294.11* With Behavioral Disturbance
301.6 Dependent Personality Disorder
300.6 Depersonalization Disorder
311 Depressive Disorder NOS
315.4 Developmental Coordination Disorder
799.9 Diagnosis Deferred on Axis II
799.9 Diagnosis or Condition Deferred on Axis I
313.9 Disorder of Infancy, Childhood, or Adolescence NOS
315.2 Disorder of Written Expression
312.9 Disruptive Behavior Disorder NOS
300.12 Dissociative Amnesia
300.15 Dissociative Disorder NOS
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
302.76 Dyspareunia (Not Due to a General Medical Condition)
307.47 Dyssomnia NOS
300.4 Dysthymic Disorder
307.50 Eating Disorder NOS
787.6 Encopresis, With Constipation and Overflow Incontinence
307.7 Encopresis, Without Constipation and Overflow Incontinence
307.6 Enuresis (Not Due to a General Medical Condition)
302.4 Exhibitionism
315.31 Expressive Language Disorder
Factitious Disorder
300.19 With Combined Psychological and Physical Signs and Symptoms
300.19 With Predominantly Physical Signs and Symptoms
300.16 With Predominantly Psychological Signs and Symptoms
300.19 Factitious Disorder NOS
307.59 Feeding Disorder of Infancy or Early Childhood
625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]*
625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]*
302.73 Female Orgasmic Disorder
302.72 Female Sexual Arousal Disorder
302.81 Fetishism
302.89 Frotteurism
Gender Identity Disorder
302.85 in Adolescents or Adults
302.6 in Children
302.6 Gender Identity Disorder NOS

*ICD-9-CM code valid after October 1, 2000.

300.02 Generalized Anxiety Disorder
Hallucinogen
305.30 Abuse
304.50 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.89 Persisting Perception Disorder
292.9 -Related Disorder NOS
301.50 Histrionic Personality Disorder
307.44 Hypersomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]*
302.71 Hypoactive Sexual Desire Disorder
300.7 Hypochondriasis
313.82 Identity Problem
312.30 Impulse-Control Disorder NOS
Inhalant
305.90 Abuse
304.60 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
292.82 -Induced Persisting Dementia
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
307.42 Insomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]*
312.34 Intermittent Explosive Disorder
312.32 Kleptomania
315.9 Learning Disorder NOS
Major Depressive Disorder, Recurrent
296.36 In Full Remission
296.35 In Partial Remission
296.31 Mild
296.32 Moderate
296.33 Severe Without Psychotic Features
296.34 Severe With Psychotic Features
296.30 Unspecified
Major Depressive Disorder, Single Episode
296.26 In Full Remission
296.25 In Partial Remission
296.21 Mild

296.22 Moderate
296.23 Severe Without Psychotic Features
296.24 Severe With Psychotic Features
296.20 Unspecified
608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]*
302.72 Male Erectile Disorder
607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition]*
608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]*
302.74 Male Orgasmic Disorder
V65.2 Malingering
315.1 Mathematics Disorder
Medication-Induced
333.90 Movement Disorder NOS
333.1 Postural Tremor
293.9 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]*
319 Mental Retardation, Severity Unspecified
317 Mild Mental Retardation
315.32 Mixed Receptive-Expressive Language Disorder
318.0 Moderate Mental Retardation
293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition]*
296.90 Mood Disorder NOS
301.81 Narcissistic Personality Disorder
347 Narcolepsy
V61.21 Neglect of Child
995.52 Neglect of Child *(if focus of attention is on victim)*
Neuroleptic-Induced
333.99 Acute Akathisia
333.7 Acute Dystonia
332.1 Parkinsonism
333.82 Tardive Dyskinesia
333.92 Neuroleptic Malignant Syndrome
Nicotine
305.1 Dependence
292.9 -Related Disorder NOS
292.0 Withdrawal
307.47 Nightmare Disorder
V71.09 No Diagnosis on Axis II
V71.09 No Diagnosis or Condition on Axis I
V15.81 Noncompliance With Treatment
300.3 Obsessive-Compulsive Disorder
301.4 Obsessive-Compulsive Personality Disorder
V62.2 Occupational Problem
Opioid
305.50 Abuse
304.00 Dependence
292.84 -Induced Mood Disorder

-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
292.0 Withdrawal
313.81 Oppositional Defiant Disorder
625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]*
608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]*
Other (or Unknown) Substance
305.90 Abuse
304.90 Dependence
292.89 –Induced Anxiety Disorder
292.81 –Induced Delirium
292.84 –Induced Mood Disorder
292.83 –Induced Persisting Amnestic Disorder
292.82 –Induced Persisting Dementia
–Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 –Induced Sexual Dysfunction
292.89 –Induced Sleep Disorder
292.89 Intoxication
292.9 –Related Disorder NOS
292.0 Withdrawal
Pain Disorder
307.89 Associated With Both Psychological Factors and a General Medical Condition
307.80 Associated With Psychological Factors
Panic Disorder
300.21 With Agoraphobia
300.01 Without Agoraphobia
301.0 Paranoid Personality Disorder
302.9 Paraphilia NOS
307.47 Parasomnia NOS
V61.20 Parent-Child Relational Problem
V61.10 Partner Relational Problem
312.31 Pathological Gambling
302.2 Pedophilia
310.1 Personality Change Due to . . . *[Indicate the General Medical Condition]*
301.9 Personality Disorder NOS
299.80 Pervasive Developmental Disorder NOS

V62.89 Phase of Life Problem
Phencyclidine (or Phencyclidine-Like)
305.90 Abuse
304.60 Dependence
292.89 –Induced Anxiety Disorder
292.84 –Induced Mood Disorder
–Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 Intoxication
292.81 Intoxication Delirium
292.9 –Related Disorder NOS
315.39 Phonological Disorder
V61.12 Physical Abuse of Adult (if by partner)
V62.83 Physical Abuse of Adult (if by person other than partner)
995.81 Physical Abuse of Adult *(if focus of attention is on victim)*
V61.21 Physical Abuse of Child
995.54 Physical Abuse of Child *(if focus of attention is on victim)*
307.52 Pica
304.80 Polysubstance Dependence
309.81 Posttraumatic Stress Disorder
302.75 Premature Ejaculation
307.44 Primary Hypersomnia
307.42 Primary Insomnia
318.2 Profound Mental Retardation
316 Psychological Factor Affecting Medical Condition
Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]*
293.81 With Delusions
293.82 With Hallucinations
298.9 Psychotic Disorder NOS
312.33 Pyromania
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
315.00 Reading Disorder
V62.81 Relational Problem NOS
V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
V62.89 Religious or Spiritual Problem
299.80 Rett's Disorder
307.53 Rumination Disorder
295.70 Schizoaffective Disorder
301.20 Schizoid Personality Disorder
Schizophrenia
295.20 Catatonic Type
295.10 Disorganized Type
295.30 Paranoid Type
295.60 Residual Type
295.90 Undifferentiated Type

295.40 Schizophreniform Disorder
301.22 Schizotypal Personality Disorder
Sedative, Hypnotic, or Anxiolytic
305.40 Abuse
304.10 Dependence
292.89 -Induced Anxiety Disorder
292.84 -Induced Mood Disorder
292.83 -Induced Persisting Amnestic Disorder
292.82 -Induced Persisting Dementia
-Induced Psychotic Disorder
292.11 With Delusions
292.12 With Hallucinations
292.89 -Induced Sexual Dysfunction
292.89 -Induced Sleep Disorder
292.89 Intoxication
292.81 Intoxication Delirium
292.9 -Related Disorder NOS
292.0 Withdrawal
292.81 Withdrawal Delirium
313.23 Selective Mutism
309.21 Separation Anxiety Disorder
318.1 Severe Mental Retardation
V61.12 Sexual Abuse of Adult (if by partner)
V62.83 Sexual Abuse of Adult (if by person other than partner)
995.83 Sexual Abuse of Adult *(if focus of attention is on victim)*
V61.21 Sexual Abuse of Child
995.53 Sexual Abuse of Child *(if focus of attention is on victim)*
302.79 Sexual Aversion Disorder
302.9 Sexual Disorder NOS
302.70 Sexual Dysfunction NOS
302.83 Sexual Masochism
302.84 Sexual Sadism
297.3 Shared Psychotic Disorder
V61.8 Sibling Relational Problem
Sleep Disorder Due to . . . *[Indicate the General Medical Condition]*
780.54 Hypersomnia Type
780.52 Insomnia Type
780.59 Mixed Type
780.59 Parasomnia Type
307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
300.23 Social Phobia
300.81 Somatization Disorder
300.82 Somatoform Disorder NOS
300.29 Specific Phobia
307.3 Stereotypic Movement Disorder
307.0 Stuttering

307.20 Tic Disorder NOS
307.23 Tourette's Disorder
307.21 Transient Tic Disorder
302.3 Transvestic Fetishism
312.39 Trichotillomania
300.82 Undifferentiated Somatoform Disorder
300.9 Unspecified Mental Disorder (nonpsychotic)
306.51 Vaginismus (Not Due to a General Medical Condition)
Vascular Dementia
290.40 Uncomplicated
290.41 With Delirium
290.42 With Delusions
290.43 With Depressed Mood
302.82 Voyeurism

Appendix F

Numerical Listing of DSM-IV-TR Diagnoses and Codes

To maintain compatibility with ICD-9-CM, some DSM-IV diagnoses share the same code numbers. These are indicated in this list by brackets.

NOS = Not Otherwise Specified.

290.40 Vascular Dementia, Uncomplicated
290.41 Vascular Dementia, With Delirium
290.42 Vascular Dementia, With Delusions
290.43 Vascular Dementia, With Depressed Mood
291.0 Alcohol Intoxication Delirium
291.0 Alcohol Withdrawal Delirium
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.2 Alcohol-Induced Persisting Dementia
291.3 Alcohol-Induced Psychotic Disorder, With Hallucinations
291.5 Alcohol-Induced Psychotic Disorder, With Delusions
291.81 Alcohol Withdrawal
291.89 Alcohol-Induced Anxiety Disorder
291.89 Alcohol-Induced Mood Disorder
291.89 Alcohol-Induced Sexual Dysfunction
291.89 Alcohol-Induced Sleep Disorder
291.9 Alcohol-Related Disorder NOS
292.0 Amphetamine Withdrawal
292.0 Cocaine Withdrawal
292.0 Nicotine Withdrawal
292.0 Opioid Withdrawal
292.0 Other (or Unknown) Substance Withdrawal
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal
292.11 Amphetamine-Induced Psychotic Disorder, With Delusions
292.11 Cannabis-Induced Psychotic Disorder, With Delusions
292.11 Cocaine-Induced Psychotic Disorder, With Delusions
292.11 Hallucinogen-Induced Psychotic Disorder, With Delusions
292.11 Inhalant-Induced Psychotic Disorder, With Delusions
292.11 Opioid-Induced Psychotic Disorder, With Delusions

292.11 Other (or Unknown) Substance–Induced Psychotic Disorder, With Delusions
292.11 Phencyclidine-Induced Psychotic Disorder, With Delusions
292.11 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Delusions
292.12 Amphetamine-Induced Psychotic Disorder, With Hallucinations
292.12 Cannabis-Induced Psychotic Disorder, With Hallucinations
292.12 Cocaine-Induced Psychotic Disorder, With Hallucinations
292.12 Hallucinogen-Induced Psychotic Disorder, With Hallucinations
292.12 Inhalant-Induced Psychotic Disorder, With Hallucinations
292.12 Opioid-Induced Psychotic Disorder, With Hallucinations
292.12 Other (or Unknown) Substance–Induced Psychotic Disorder, With Hallucinations
292.12 Phencyclidine-Induced Psychotic Disorder, With Hallucinations
292.12 Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations
292.81 Amphetamine Intoxication Delirium
292.81 Cannabis Intoxication Delirium
292.81 Cocaine Intoxication Delirium
292.81 Hallucinogen Intoxication Delirium
292.81 Inhalant Intoxication Delirium
292.81 Opioid Intoxication Delirium
292.81 Other (or Unknown) Substance–Induced Delirium
292.81 Phencyclidine Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.82 Inhalant-Induced Persisting Dementia
292.82 Other (or Unknown) Substance–Induced Persisting Dementia
292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83 Other (or Unknown) Substance–Induced Persisting Amnestic Disorder
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder
292.84 Amphetamine-Induced Mood Disorder
292.84 Cocaine-Induced Mood Disorder
292.84 Hallucinogen-Induced Mood Disorder
292.84 Inhalant-Induced Mood Disorder
292.84 Opioid-Induced Mood Disorder
292.84 Other (or Unknown) Substance–Induced Mood Disorder
292.84 Phencyclidine-Induced Mood Disorder
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder
292.89 Amphetamine-Induced Anxiety Disorder
292.89 Amphetamine-Induced Sexual Dysfunction
292.89 Amphetamine-Induced Sleep Disorder
292.89 Amphetamine Intoxication
292.89 Caffeine-Induced Anxiety Disorder
292.89 Caffeine-Induced Sleep Disorder
292.89 Cannabis-Induced Anxiety Disorder
292.89 Cannabis Intoxication
292.89 Cocaine-Induced Anxiety Disorder

292.89 Cocaine-Induced Sexual Dysfunction
292.89 Cocaine-Induced Sleep Disorder
292.89 Cocaine Intoxication
292.89 Hallucinogen-Induced Anxiety Disorder
292.89 Hallucinogen Intoxication
292.89 Hallucinogen Persisting Perception Disorder
292.89 Inhalant-Induced Anxiety Disorder
292.89 Inhalant Intoxication
292.89 Opioid-Induced Sexual Dysfunction
292.89 Opioid-Induced Sleep Disorder
292.89 Opioid Intoxication
292.89 Other (or Unknown) Substance–Induced Anxiety Disorder
292.89 Other (or Unknown) Substance–Induced Sexual Dysfunction
292.89 Other (or Unknown) Substance–Induced Sleep Disorder
292.89 Other (or Unknown) Substance Intoxication
292.89 Phencyclidine-Induced Anxiety Disorder
292.89 Phencyclidine Intoxication
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder
292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.9 Amphetamine-Related Disorder NOS
292.9 Caffeine-Related Disorder NOS
292.9 Cannabis-Related Disorder NOS
292.9 Cocaine-Related Disorder NOS
292.9 Hallucinogen-Related Disorder NOS
292.9 Inhalant-Related Disorder NOS
292.9 Nicotine-Related Disorder NOS
292.9 Opioid-Related Disorder NOS
292.9 Other (or Unknown) Substance–Related Disorder NOS
292.9 Phencyclidine-Related Disorder NOS
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS
293.0 Delirium Due to . . . *[Indicate the General Medical Condition]*
293.81 Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]*, With Delusions
293.82 Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]*, With Hallucinations
293.83 Mood Disorder Due to . . . *[Indicate the General Medical Condition]*
293.84 Anxiety Disorder Due to . . . *[Indicate the General Medical Condition]*
293.89 Catatonic Disorder Due to . . . *[Indicate the General Medical Condition]*
293.9 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]*
294.0 Amnestic Disorder Due to . . . *[Indicate the General Medical Condition]*
294.10* Dementia Due to . . . *[Indicate the General Medical Condition]*, Without Behavioral Disturbance

*ICD-9-CM code valid after October 1, 2000.

294.10* Dementia of the Alzheimer's Type, With Early Onset, Without Behavioral Disturbance
294.10* Dementia of the Alzheimer's Type, With Late Onset, Without Behavioral Disturbance
294.11* Dementia Due to . . . *[Indicate the General Medical Condition]*, With Behavioral Disturbance
294.11* Dementia of the Alzheimer's Type, With Early Onset, With Behavioral Disturbance
294.11* Dementia of the Alzheimer's Type, With Late Onset, With Behavioral Disturbance
294.8 Amnestic Disorder NOS
294.8 Dementia NOS
294.9 Cognitive Disorder NOS
295.10 Schizophrenia, Disorganized Type
295.20 Schizophrenia, Catatonic Type
295.30 Schizophrenia, Paranoid Type
295.40 Schizophreniform Disorder
295.60 Schizophrenia, Residual Type
295.70 Schizoaffective Disorder
295.90 Schizophrenia, Undifferentiated Type
296.00 Bipolar I Disorder, Single Manic Episode, Unspecified
296.01 Bipolar I Disorder, Single Manic Episode, Mild
296.02 Bipolar I Disorder, Single Manic Episode, Moderate
296.03 Bipolar I Disorder, Single Manic Episode, Severe Without Psychotic Features
296.04 Bipolar I Disorder, Single Manic Episode, Severe With Psychotic Features
296.05 Bipolar I Disorder, Single Manic Episode, In Partial Remission
296.06 Bipolar I Disorder, Single Manic Episode, In Full Remission
296.20 Major Depressive Disorder, Single Episode, Unspecified
296.21 Major Depressive Disorder, Single Episode, Mild
296.22 Major Depressive Disorder, Single Episode, Moderate
296.23 Major Depressive Disorder, Single Episode, Severe Without Psychotic Features
296.24 Major Depressive Disorder, Single Episode, Severe With Psychotic Features
296.25 Major Depressive Disorder, Single Episode, In Partial Remission
296.26 Major Depressive Disorder, Single Episode, In Full Remission
296.30 Major Depressive Disorder, Recurrent, Unspecified
296.31 Major Depressive Disorder, Recurrent, Mild
296.32 Major Depressive Disorder, Recurrent, Moderate
296.33 Major Depressive Disorder, Recurrent, Severe Without Psychotic Features
296.34 Major Depressive Disorder, Recurrent, Severe With Psychotic Features
296.35 Major Depressive Disorder, Recurrent, In Partial Remission
296.36 Major Depressive Disorder, Recurrent, In Full Remission
296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
296.40 Bipolar I Disorder, Most Recent Episode Manic, Unspecified
296.41 Bipolar I Disorder, Most Recent Episode Manic, Mild

*ICD-9-CM code valid after October 1, 2000.

296.42 Bipolar I Disorder, Most Recent Episode Manic, Moderate
296.43 Bipolar I Disorder, Most Recent Episode Manic, Severe Without Psychotic Features
296.44 Bipolar I Disorder, Most Recent Episode Manic, Severe With Psychotic Features
296.45 Bipolar I Disorder, Most Recent Episode Manic, In Partial Remission
296.46 Bipolar I Disorder, Most Recent Episode Manic, In Full Remission
296.50 Bipolar I Disorder, Most Recent Episode Depressed, Unspecified
296.51 Bipolar I Disorder, Most Recent Episode Depressed, Mild
296.52 Bipolar I Disorder, Most Recent Episode Depressed, Moderate
296.53 Bipolar I Disorder, Most Recent Episode Depressed, Severe Without Psychotic Features
296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features
296.55 Bipolar I Disorder, Most Recent Episode Depressed, In Partial Remission
296.56 Bipolar I Disorder, Most Recent Episode Depressed, In Full Remission
296.60 Bipolar I Disorder, Most Recent Episode Mixed, Unspecified
296.61 Bipolar I Disorder, Most Recent Episode Mixed, Mild
296.62 Bipolar I Disorder, Most Recent Episode Mixed, Moderate
296.63 Bipolar I Disorder, Most Recent Episode Mixed, Severe Without Psychotic Features
296.64 Bipolar I Disorder, Most Recent Episode Mixed, Severe With Psychotic Features
296.65 Bipolar I Disorder, Most Recent Episode Mixed, In Partial Remission
296.66 Bipolar I Disorder, Most Recent Episode Mixed, In Full Remission
296.7 Bipolar I Disorder, Most Recent Episode Unspecified
296.80 Bipolar Disorder NOS
296.89 Bipolar II Disorder
296.90 Mood Disorder NOS
297.1 Delusional Disorder
297.3 Shared Psychotic Disorder
298.8 Brief Psychotic Disorder
298.9 Psychotic Disorder NOS
299.00 Autistic Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS
299.80 Rett's Disorder
300.00 Anxiety Disorder NOS
300.01 Panic Disorder Without Agoraphobia
300.02 Generalized Anxiety Disorder
300.11 Conversion Disorder
300.12 Dissociative Amnesia
300.13 Dissociative Fugue
300.14 Dissociative Identity Disorder
300.15 Dissociative Disorder NOS
300.16 Factitious Disorder With Predominantly Psychological Signs and Symptoms

300.19 Factitious Disorder NOS
300.19 Factitious Disorder With Combined Psychological and Physical Signs and Symptoms
300.19 Factitious Disorder With Predominantly Physical Signs and Symptoms
300.21 Panic Disorder With Agoraphobia
300.22 Agoraphobia Without History of Panic Disorder
300.23 Social Phobia
300.29 Specific Phobia
300.3 Obsessive-Compulsive Disorder
300.4 Dysthymic Disorder
300.6 Depersonalization Disorder
300.7 Body Dysmorphic Disorder
300.7 Hypochondriasis
300.81 Somatization Disorder
300.82 Somatoform Disorder NOS
300.82 Undifferentiated Somatoform Disorder
300.9 Unspecified Mental Disorder (nonpsychotic)
301.0 Paranoid Personality Disorder
301.13 Cyclothymic Disorder
301.20 Schizoid Personality Disorder
301.22 Schizotypal Personality Disorder
301.4 Obsessive-Compulsive Personality Disorder
301.50 Histrionic Personality Disorder
301.6 Dependent Personality Disorder
301.7 Antisocial Personality Disorder
301.81 Narcissistic Personality Disorder
301.82 Avoidant Personality Disorder
301.83 Borderline Personality Disorder
301.9 Personality Disorder NOS
302.2 Pedophilia
302.3 Transvestic Fetishism
302.4 Exhibitionism
302.6 Gender Identity Disorder in Children
302.6 Gender Identity Disorder NOS
302.70 Sexual Dysfunction NOS
302.71 Hypoactive Sexual Desire Disorder
302.72 Female Sexual Arousal Disorder
302.72 Male Erectile Disorder
302.73 Female Orgasmic Disorder
302.74 Male Orgasmic Disorder
302.75 Premature Ejaculation
302.76 Dyspareunia (Not Due to a General Medical Condition)
302.79 Sexual Aversion Disorder
302.81 Fetishism
302.82 Voyeurism
302.83 Sexual Masochism
302.84 Sexual Sadism

302.85 Gender Identity Disorder in Adolescents or Adults
302.89 Frotteurism
302.9 Paraphilia NOS
302.9 Sexual Disorder NOS
303.00 Alcohol Intoxication
303.90 Alcohol Dependence
304.00 Opioid Dependence
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
304.20 Cocaine Dependence
304.30 Cannabis Dependence
304.40 Amphetamine Dependence
304.50 Hallucinogen Dependence
304.60 Inhalant Dependence
304.60 Phencyclidine Dependence
304.80 Polysubstance Dependence
304.90 Other (or Unknown) Substance Dependence
305.00 Alcohol Abuse
305.1 Nicotine Dependence
305.20 Cannabis Abuse
305.30 Hallucinogen Abuse
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
305.50 Opioid Abuse
305.60 Cocaine Abuse
305.70 Amphetamine Abuse
305.90 Caffeine Intoxication
305.90 Inhalant Abuse
305.90 Other (or Unknown) Substance Abuse
305.90 Phencyclidine Abuse
306.51 Vaginismus (Not Due to a General Medical Condition)
307.0 Stuttering
307.1 Anorexia Nervosa
307.20 Tic Disorder NOS
307.21 Transient Tic Disorder
307.22 Chronic Motor or Vocal Tic Disorder
307.23 Tourette's Disorder
307.3 Stereotypic Movement Disorder
307.42 Insomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]*
307.42 Primary Insomnia
307.44 Hypersomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]*
307.44 Primary Hypersomnia
307.45 Circadian Rhythm Sleep Disorder
307.46 Sleep Terror Disorder
307.46 Sleepwalking Disorder
307.47 Dyssomnia NOS
307.47 Nightmare Disorder
307.47 Parasomnia NOS
307.50 Eating Disorder NOS

307.51 Bulimia Nervosa
307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood
307.6 Enuresis (Not Due to a General Medical Condition)
307.7 Encopresis, Without Constipation and Overflow Incontinence
307.80 Pain Disorder Associated With Psychological Factors
307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition
307.9 Communication Disorder NOS
308.3 Acute Stress Disorder
309.0 Adjustment Disorder With Depressed Mood
309.21 Separation Anxiety Disorder
309.24 Adjustment Disorder With Anxiety
309.28 Adjustment Disorder With Mixed Anxiety and Depressed Mood
309.3 Adjustment Disorder With Disturbance of Conduct
309.4 Adjustment Disorder With Mixed Disturbance of Emotions and Conduct
309.81 Posttraumatic Stress Disorder
309.9 Adjustment Disorder Unspecified
310.1 Personality Change Due to . . . *[Indicate the General Medical Condition]*
311 Depressive Disorder NOS
312.30 Impulse-Control Disorder NOS
312.31 Pathological Gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent Explosive Disorder
312.39 Trichotillomania
312.81 Conduct Disorder, Childhood-Onset Type
312.82 Conduct Disorder, Adolescent-Onset Type
312.89 Conduct Disorder, Unspecified Onset
312.9 Disruptive Behavior Disorder NOS
313.23 Selective Mutism
313.81 Oppositional Defiant Disorder
313.82 Identity Problem
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
313.9 Disorder of Infancy, Childhood, or Adolescence NOS
314.00 Attention-Deficit/Hyperactivity Disorder, Predominantly Inattentive Typ
314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type
314.01 Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
315.00 Reading Disorder
315.1 Mathematics Disorder
315.2 Disorder of Written Expression
315.31 Expressive Language Disorder
315.32 Mixed Receptive-Expressive Language Disorder
315.39 Phonological Disorder

315.4 Developmental Coordination Disorder
315.9 Learning Disorder NOS
316 . . . *[Specified Psychological Factor]* Affecting . . . *[Indicate the General Medical Condition]*
317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified
332.1 Neuroleptic-Induced Parkinsonism
333.1 Medication-Induced Postural Tremor
333.7 Neuroleptic-Induced Acute Dystonia
333.82 Neuroleptic-Induced Tardive Dyskinesia
333.90 Medication-Induced Movement Disorder NOS
333.92 Neuroleptic Malignant Syndrome
333.99 Neuroleptic-Induced Acute Akathisia
347 Narcolepsy
607.84 Male Erectile Disorder Due to . . . *[Indicate the General Medical Condition]*
608.89 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]*
608.89 Male Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the Medical Condition]*
608.89 Other Male Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]*
625.0 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]*
625.8 Female Hypoactive Sexual Desire Disorder Due to . . . *[Indicate the General Medical Condition]*
625.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]*
780.09 Delirium NOS
780.52 Sleep Disorder Due to . . . *[Indicate the General Medical Condition]*, Insomnia Type
780.54 Sleep Disorder Due to . . . *[Indicate the General Medical Condition]*, Hypersomnia Type
780.59 Breathing-Related Sleep Disorder
780.59 Sleep Disorder Due to . . . *[Indicate the General Medical Condition]*, Mixed Type
780.59 Sleep Disorder Due to . . . *[Indicate the General Medical Condition]*, Parasomnia Type
780.9 Age-Related Cognitive Decline
787.6 Encopresis, With Constipation and Overflow Incontinence
799.9 Diagnosis Deferred on Axis II
799.9 Diagnosis or Condition Deferred on Axis I
995.2 Adverse Effects of Medication NOS
995.52 Neglect of Child *(if focus of attention is on victim)*
995.53 Sexual Abuse of Child *(if focus of attention is on victim)*
995.54 Physical Abuse of Child *(if focus of attention is on victim)*
995.81 Physical Abuse of Adult *(if focus of attention is on victim)*
995.83 Sexual Abuse of Adult *(if focus of attention is on victim)*

V15.81 Noncompliance With Treatment
V61.10 Partner Relational Problem
V61.12 Physical Abuse of Adult (if by partner)
V61.12 Sexual Abuse of Adult (if by partner)
V61.20 Parent-Child Relational Problem
V61.21 Neglect of Child
V61.21 Physical Abuse of Child
V61.21 Sexual Abuse of Child
V61.8 Sibling Relational Problem
V61.9 Relational Problem Related to a Mental Disorder or General Medical Condition
V62.2 Occupational Problem
V62.3 Academic Problem
V62.4 Acculturation Problem
V62.81 Relational Problem NOS
V62.82 Bereavement
V62.83 Physical Abuse of Adult (if by person other than partner)
V62.83 Sexual Abuse of Adult (if by person other than partner)
V62.89 Borderline Intellectual Functioning
V62.89 Phase of Life Problem
V62.89 Religious or Spiritual Problem
V65.2 Malingering
V71.01 Adult Antisocial Behavior
V71.02 Child or Adolescent Antisocial Behavior
V71.09 No Diagnosis on Axis II
V71.09 No Diagnosis or Condition on Axis I

Appendix G

ICD-9-CM Codes for Selected General Medical Conditions and Medication-Induced Disorders

Updated to include ICD-9-CM codes effective October 1, 2000

The official coding system in use as of the publication of DSM-IV is the *International Classification of Diseases*, 9th Revision, Clinical Modification (ICD-9-CM). This appendix contains two sections that are provided to facilitate ICD-9-CM coding: 1) codes for selected general medical conditions, and 2) codes for medication-induced disorders.

ICD-9-CM Codes for Selected General Medical Conditions

The codes specified for use on Axis I and Axis II of DSM-IV represent only a small fraction of the codes provided in ICD-9-CM. The conditions classified outside the "Mental Disorders" chapter of ICD-9-CM are also important for clinical diagnosis and management in mental health settings. Axis III is provided to facilitate the reporting of these conditions (see p. 29). To assist clinicians in finding the ICD-9-CM codes, this appendix provides a selective index of those ICD-9-CM codes for general medical conditions that are most relevant to diagnosis and care in mental health settings. ICD-9-CM offers diagnostic specificity beyond that reflected in many of the codes that appear in this appendix (e.g., to denote a specific anatomical site or the presence of a specific complication). In cases in which increased specificity is noted in the fifth digit of the code, the least specific code (usually "0") has been selected. For example, the code for lymphosarcoma is given as 200.10 (for unspecified site), although more specificity with regard to anatomical site can be noted in the other fifth-digit codes, for example, 200.12 lymphosarcoma, intrathoracic lymph nodes. In cases in which increased specificity is reflected in the fourth digit of the code, this appendix often provides the "unspecified" category (e.g., 555.9 is listed for regional enteritis; ICD-9-CM also includes 555.0 for enteritis involving the small intestine, 555.1 for involvement of the large intestine, and 555.2 for involvement of both). Diagnostic codes for which more specificity is available are indicated in this appendix by an asterisk (*). Clinicians interested in recording greater specificity should refer to the complete listing of codes published in the ICD-9-CM Diseases: Tabular List (Volume 1) and the ICD-9-CM Dis-

eases: Alphabetic Index (Volume 2). These documents are updated every October and are published by the U.S. Department of Health and Human Services. They are available from the Superintendent of Documents, U.S. Government Printing Office, as well as from a number of private publishers.

Note: An asterisk (*) following the ICD-9-CM code indicates that greater specificity (e.g., a specific complication or anatomical site) is available. Refer to the ICD-9-CM Diseases: Tabular List (Volume 1) entry for that code for additional information.

Diseases of the Nervous System

324.0 Abscess, intracranial
331.0 Alzheimer's disease
437.0 Atherosclerosis, cerebral
354.0 Carpal tunnel syndrome
354.4 Causalgia
334.3 Cerebellar ataxia
850.9* Concussion
851.80* Contusion, cerebral
359.1 Dystrophy, Duchenne's muscular
348.5 Edema, cerebral
049.9* Encephalitis, viral
572.2 Encephalopathy, hepatic
437.2 Encephalopathy, hypertensive
348.3* Encephalopathy, unspecified
345.10* Epilepsy, grand mal
345.40* Epilepsy, partial, with impairment of consciousness (temporal lobe)
345.50* Epilepsy, partial, without impairment of consciousness (Jacksonian)
345.00* Epilepsy, petit mal (absences)
346.20 Headache, cluster
432.0 Hemorrhage, extradural, nontraumatic
852.40* Hemorrhage, extradural, traumatic
431 Hemorrhage, intracerebral, nontraumatic
430 Hemorrhage, subarachnoid, nontraumatic
852.00* Hemorrhage, subarachnoid, traumatic
432.1 Hemorrhage, subdural, nontraumatic
852.20* Hemorrhage, subdural, traumatic
333.4 Huntington's chorea
331.3 Hydrocephalus, communicating
331.4 Hydrocephalus, obstructive
435.9* Ischemic attack, transient
046.1 Jakob-Creutzfeldt disease
046.0 Kuru
046.3 Leukoencephalopathy, progressive multifocal
330.1 Lipidosis, cerebral
320.9* Meningitis, bacterial (due to unspecified bacterium)
321.0 Meningitis, cryptococcal
054.72 Meningitis, herpes simplex virus

053.0 Meningitis, herpes zoster
321.1* Meningitis, other fungal
094.2 Meningitis, syphilitic
047.9* Meningitis, viral (due to unspecified virus)
346.00* Migraine, classical (with aura)
346.10* Migraine, common
346.90* Migraine, unspecified
358.0 Myasthenia gravis
350.1 Neuralgia, trigeminal
337.1 Neuropathy, peripheral autonomic
434.9* Occlusion, cerebral artery
350.2 Pain, face, atypical
351.0 Palsy, Bell's
343.9* Palsy, cerebral
335.23 Palsy, pseudobulbar
046.2 Panencephalitis, subacute sclerosing
094.1 Paresis, general
332.0 Parkinson's disease, primary
331.1 Pick's disease
357.9* Polyneuropathy
348.2 Pseudotumor cerebri (benign intracranial hypertension)
335.20 Sclerosis, amyotrophic lateral
340 Sclerosis, multiple (MS)
345.3 Status, grand mal
345.2 Status, petit mal
345.70 Status, temporal lobe
433.1 Stenosis, carotid artery, without cerebral infarction
436 Stroke (CVA)
330.1 Tay-Sachs disease
333.1 Tremor, benign essential

Diseases of the Circulatory System

413.9* Angina pectoris
424.1 Aortic valve disorder
440.9* Atherosclerosis
426.10* Block, atrioventricular
426.3* Block, left bundle branch
426.4 Block, right bundle branch
427.5 Cardiac arrest
425.5 Cardiomyopathy, alcoholic
425.4* Cardiomyopathy, idiopathic
416.9* Chronic pulmonary heart disease
414.00* Coronary atherosclerosis
427.9* Dysrhythmia, cardiac, unspecified
415.19* Embolism, pulmonary
421.9* Endocarditis, bacterial

428.0* Failure, congestive heart
427.31 Fibrillation, atrial
427.41 Fibrillation, ventricular
427.32 Flutter, atrial
427.42 Flutter, ventricular
455.6* Hemorrhoids
401.9* Hypertension, essential
402.91* Hypertensive heart disease with congestive heart failure
402.90* Hypertensive heart disease without congestive heart failure
403.91* Hypertensive renal disease with failure
403.90* Hypertensive renal disease without failure
458.0 Hypotension, orthostatic
410.90* Infarction, myocardial, acute
424.0 Mitral valve insufficiency (nonrheumatic)
424.0 Mitral valve prolapse
394.0* Mitral valve stenosis (rheumatic)
423.9* Pericarditis
443.9* Peripheral vascular disease
451.9* Phlebitis/thrombophlebitis
446.0 Polyarteritis nodosa
427.60* Premature beats
424.3 Pulmonary valve disease (nonrheumatic)
397.1 Pulmonary valve disease, rheumatic
427.0 Tachycardia, paroxysmal supraventricular
427.2 Tachycardia, paroxysmal, unspecified
427.1 Tachycardia, ventricular (paroxysmal)
424.2 Tricuspid valve disease (nonrheumatic)
397.0 Tricuspid valve disease, rheumatic
456.0 Varices, esophageal, with bleeding
456.1 Varices, esophageal, without bleeding
454.9* Varicose veins, lower extremities

Diseases of the Respiratory System

513.0 Abscess of lung
518.0 Atelectasis
493.20* Asthma, chronic obstructive
493.90* Asthma, unspecified
494.1 Bronchiectasis, acute
466.0 Bronchitis, acute
491.21 Bronchitis, obstructive chronic (COPD), with acute exacerbation
491.20 Bronchitis, obstructive chronic (COPD), without acute exacerbation
277.00* Cystic fibrosis
511.9* Effusion, pleural
492.8* Emphysema
518.81* Failure, respiratory
505 Pneumoconiosis

860.4* Pneumohemothorax, traumatic
483.0 Pneumonia, mycoplasma
482.9* Pneumonia, unspecified bacterial
481 Pneumonia, pneumococcal
136.3 Pneumonia, pneumocystis
482.30* Pneumonia, streptococcus
486* Pneumonia, unspecified organism
480.9* Pneumonia, viral
512.8* Pneumothorax, spontaneous
860.0* Pneumothorax, traumatic
011.9* Tuberculosis, pulmonary

Neoplasms

ICD-9-CM diagnostic codes for neoplasms are classified in the table of neoplasms in the ICD-9-CM Alphabetic Index (Volume 2) according to site and degree of malignancy (primary, secondary, in situ, benign, uncertain, unspecified). **Note:** For patients with a personal history of malignant neoplasms that have been surgically removed or eradicated by chemotherapy or radiation therapy, codes V10.0–V10.9 should be used; for specific sites, refer to the Alphabetic Index (Volume 2) of ICD-9-CM under "History (personal) of, malignant neoplasm."

Listed below are some of the most common codes assigned for neoplasms.

228.02 Hemangioma of brain
201.90* Hodgkin's disease
176.9* Kaposi's sarcoma
208.01* Leukemia, acute, in remission
208.00* Leukemia, acute
208.11* Leukemia, chronic, in remission
208.10* Leukemia, chronic
200.10* Lymphosarcoma
225.2 Meningioma (cerebral)
203.01 Multiple myeloma, in remission
203.00 Multiple myeloma
225.0 Neoplasm, benign, of brain
211.4 Neoplasm, benign, of colon
195.2 Neoplasm, malignant, abdominal cavity, primary
194.0 Neoplasm, malignant, adrenal gland, primary
188.9* Neoplasm, malignant, bladder, primary
170.9* Neoplasm, malignant, bone, primary
198.5 Neoplasm, malignant, bone, secondary
191.9* Neoplasm, malignant, brain, primary
198.3 Neoplasm, malignant, brain, secondary
174.9* Neoplasm, malignant, breast, female, primary
175.9* Neoplasm, malignant, breast, male, primary
162.9* Neoplasm, malignant, bronchus, primary
180.9* Neoplasm, malignant, cervix, primary

153.9* Neoplasm, malignant, colon, primary
197.5 Neoplasm, malignant, colon, secondary
171.9* Neoplasm, malignant, connective tissue, primary
150.9* Neoplasm, malignant, esophagus, primary
152.9* Neoplasm, malignant, intestine, small, primary
189.0* Neoplasm, malignant, kidney, primary
155.0 Neoplasm, malignant, liver, primary
197.7 Neoplasm, malignant, liver, secondary
162.9* Neoplasm, malignant, lung, primary
197.0 Neoplasm, malignant, lung, secondary
196.9* Neoplasm, malignant, lymph nodes, secondary
172.9* Neoplasm, malignant, melanoma, primary
183.0* Neoplasm, malignant, ovary, primary
157.9* Neoplasm, malignant, pancreas, primary
185 Neoplasm, malignant, prostate, primary
154.1 Neoplasm, malignant, rectum, primary
173.9* Neoplasm, malignant, skin, primary
151.9* Neoplasm, malignant, stomach, site unspecified, primary
186.9* Neoplasm, malignant, testis, primary
193 Neoplasm, malignant, thyroid, primary
179* Neoplasm, malignant, uterus, primary
237.70* Neurofibromatosis
227.0 Pheochromocytoma, benign
194.0 Pheochromocytoma, malignant
238.4 Polycythemia vera

Endocrine Diseases

253.0 Acromegaly
255.2 Adrenogenital disorder
259.2 Carcinoid syndrome
255.4 Corticoadrenal insufficiency
255.0 Cushing's syndrome
253.5 Diabetes insipidus
250.00* Diabetes mellitus, type II/non-insulin-dependent
250.01* Diabetes mellitus, type I/insulin-dependent
253.2 Dwarfism, pituitary
241.9* Goiter, nontoxic nodular
240.9* Goiter, simple
255.1 Hyperaldosteronism
252.0 Hyperparathyroidism
252.1 Hypoparathyroidism
244.9* Hypothyroidism, acquired
243 Hypothyroidism, congenital
256.9* Ovarian dysfunction
253.2 Panhypopituitarism
259.0 Sexual development and puberty, delayed

259.1 Sexual development and puberty, precocious
257.9* Testicular dysfunction
245.9* Thyroiditis
242.9* Thyrotoxicosis

Nutritional Diseases

265.0 Beriberi
269.3 Calcium deficiency
266.2 Folic acid deficiency
269.3 Iodine deficiency
260 Kwashiorkor
262 Malnutrition, protein-caloric, severe
261 Nutritional marasmus
278.00* Obesity
265.2 Pellagra (niacin deficiency)
266.0 Riboflavin deficiency
264.9* Vitamin A deficiency
266.1 Vitamin B_6 deficiency
266.2 Vitamin B_{12} deficiency
267 Vitamin C deficiency
268.9* Vitamin D deficiency
269.1 Vitamin E deficiency
269.0 Vitamin K deficiency

Metabolic Diseases

276.2 Acidosis
276.3 Alkalosis
277.3 Amyloidosis
276.5 Depletion, volume (dehydration)
271.3 Disaccharide malabsorption (lactose intolerance)
276.9* Electrolyte imbalance
276.6 Fluid overload/retention
274.9* Gout
275.0 Hemochromatosis
275.42 Hypercalcemia
276.7 Hyperkalemia
276.0 Hypernatremia
275.41 Hypocalcemia
276.8 Hypokalemia
276.1 Hyponatremia
270.1 Phenylketonuria (PKU)
277.1 Porphyria
277.2 Lesch-Nyhan syndrome
275.1 Wilson's disease

Diseases of the Digestive System

540.9* Appendicitis, acute
578.9* Bleeding, gastrointestinal
575.0 Cholecystitis, acute
575.11 Cholecystitis, chronic
571.2 Cirrhosis, alcoholic
556.9* Colitis, ulcerative
564.0 Constipation
555.9* Crohn's disease
009.2 Diarrhea, infectious
558.9* Diarrhea, unspecified
562.10 Diverticulitis of colon, unspecified
562.12 Diverticulitis of colon, with hemorrhage
562.11 Diverticulosis of colon, unspecified
562.13 Diverticulosis of colon, with hemorrhage
535.50* Duodenitis and gastritis
555.9* Enteritis, regional
535.50* Gastritis and duodenitis
558.9* Gastroenteritis
530.1 Esophagitis
571.1 Hepatitis, alcoholic, acute
571.40* Hepatitis, chronic
573.3* Hepatitis, toxic (includes drug induced)
070.1* Hepatitis, viral A
070.30* Hepatitis, viral B
070.51* Hepatitis, viral C
560.39* Impaction, fecal
550.90* Inguinal hernia
564.1 Irritable bowel syndrome
576.2 Obstruction, bile duct
560.9* Obstruction, intestinal
577.0 Pancreatitis, acute
577.1 Pancreatitis, chronic
567.9* Peritonitis
530.1 Reflux, esophageal
530.4 Rupture, esophageal
530.3 Stricture, esophageal
532.30* Ulcer, duodenal, acute
532.70* Ulcer, duodenal, chronic
531.30* Ulcer, gastric, acute
531.70* Ulcer, gastric, chronic

Genitourinary System Diseases

596.4 Atonic bladder
592.0 Calculus, renal

592.1 Calculus, ureter
592.9* Calculus, urinary, unspecified
595.9* Cystitis
625.3 Dysmenorrhea
617.9* Endometriosis
584.9* Failure, renal, acute
585 Failure, renal, chronic
403.91* Failure, renal, hypertensive
586* Failure, renal, unspecified
218.9* Fibroid of uterus
580.9* Glomerulonephritis, acute
600.0 Hypertrophy, prostatic, benign (BPH)
628.9* Infertility, female
606.9* Infertility, male
627.9* Menopausal or postmenopausal disorder
626.9* Menstruation, disorder of, and abnormal bleeding
625.2 Mittelschmerz
620.2* Ovarian cyst
614.9* Pelvic inflammatory disease (PID)
607.3 Priapism
618.9* Prolapse, genital
601.9* Prostatitis
593.3 Stricture, ureteral
598.9* Stricture, urethral
599.0 Urinary tract infection (UTI)

Hematological Diseases

288.0 Agranulocytosis
287.0 Allergic purpura
284.9* Anemia, aplastic
281.2 Anemia, folate-deficiency
283.9* Anemia, hemolytic, acquired
283.11 Anemia, hemolytic-uremic syndrome
280.9* Anemia, iron-deficiency
283.10 Anemia, nonautoimmune hemolytic, unspecified
283.19 Anemia, other autoimmune hemolytic
281.0 Anemia, pernicious
282.60* Anemia, sickle-cell
286.9* Coagulation defects
288.3 Eosinophilia
282.4 Thalassemia
287.5* Thrombocytopenia

Diseases of the Eye

366.9* Cataract
372.9* Conjunctiva disorder

361.9* Detachment, retinal
365.9* Glaucoma
377.30* Neuritis, optic
379.50* Nystagmus
377.00* Papilledema
369.9* Visual loss

Diseases of the Ear, Nose, and Throat

460 Common cold
389.9* Hearing loss
464.0 Laryngitis, acute
386.00* Ménière's disease
382.9* Otitis media
462 Pharyngitis, acute
477.9* Rhinitis, allergic
461.9* Sinusitis, acute
473.9* Sinusitis, chronic
388.30* Tinnitus, unspecified
463 Tonsillitis, acute

Musculoskeletal System and Connective Tissue Diseases

716.20* Arthritis, allergic
711.90* Arthritis, infective
714.0 Arthritis, rheumatoid
733.40* Aseptic necrosis of bone
710.3 Dermatomyositis
722.91 Disc disorder, intervertebral, cervical
722.93 Disc disorder, intervertebral, lumbar
722.92 Disc disorder, intervertebral, thoracic
733.10* Fracture, pathological
715.90* Osteoarthrosis (osteoarthritis)
730.20* Osteomyelitis
733.00* Osteoporosis
710.1 Scleroderma (systemic sclerosis)
737.30 Scoliosis
710.2 Sjögren's disease
720.0 Spondylitis, ankylosing
710.0 Systemic lupus erythematosus

Diseases of the Skin

704.00* Alopecia
692.9* Dermatitis, contact
693.0* Dermatitis, due to substance (taken internally)
682.9* Cellulitis, unspecified site

695.1 Erythema multiforme
703.0 Ingrowing nail
701.4 Keloid scar
696.1* Psoriasis
707.0 Ulcer, decubitus
708.0 Urticaria, allergic

Congenital Malformations, Deformations, and Chromosomal Abnormalities

749.10* Cleft lip
749.00* Cleft palate
758.3 Cri-du-chat syndrome (antimongolism)
758.0 Down's syndrome
760.71 Fetal alcohol syndrome
751.3 Hirschsprung's disease (congenital colon dysfunction)
742.3 Hydrocephalus, congenital
752.7 Indeterminate sex and pseudohermaphroditism
758.7 Klinefelter's syndrome
759.82 Marfan's syndrome
742.1 Microcephalus
741.90* Spina bifida
750.5 Stenosis, congenital hypertrophic pyloric
760.71 Toxic effects of alcohol
760.75 Toxic effects of cocaine
760.73 Toxic effects of hallucinogens
760.72 Toxic effects of narcotics
760.70 Toxic effects of other substances (including medications)
759.5 Tuberous sclerosis
758.6 Turner's syndrome
752.51 Undescended testicle

Diseases of Pregnancy, Childbirth, and the Puerperium

Diagnoses associated with pregnancies can be located in the Alphabetic Index (Volume 2) of ICD-9-CM indented under "Pregnancy, complicated (by)," or "Pregnancy, management affected by." Listed below are some of the most common conditions.

642.00* Eclampsia
643.0* Hyperemesis gravidarum, mild
643.0* Hyperemesis gravidarum, with metabolic disturbance
642.0* Pre-eclampsia, mild
642.0* Pre-eclampsia, severe

Infectious Diseases

The following codes represent ICD-9-CM diagnostic codes for infections from specific organisms. Traditionally, codes for organisms from the 041 category are used as

secondary codes (e.g., urinary tract infection due to *Escherichia coli* would be coded as 599.0 [primary diagnosis] and 041.4 [secondary diagnosis]).

006.9* Amebiasis
112.5 Candidiasis, disseminated
112.4 Candidiasis, lung
112.0 Candidiasis, mouth
112.2 Candidiasis, other urogenital sites
112.3 Candidiasis, skin and nails
112.9 Candidiasis, unspecified site
112.1 Candidiasis, vulva and vagina
099.41 *Chlamydia trachomatis*
001.9* Cholera
041.83 *Clostridium perfrigens*
114.9* Coccidioidomycosis
078.1 *Condyloma acuminatum* (viral warts)
079.2 Coxsackie virus
117.5 Cryptococcosis
041.4 *Escherichia coli* (*E. coli*)
007.1 Giardiasis
098.2* Gonorrhea
041.5 *Hemophilus influenzae* (*H. influenzae*)
070.1* Hepatitis, viral A
070.3* Hepatitis, viral B
070.51 Hepatitis, viral C
054.9* Herpes simplex
053.9* Herpes zoster
115.9* Histoplasmosis
042 HIV infection (symptomatic)
036.9* Infection, meningococcal
079.99* Infection, viral, unspecified
487.1 Influenza, unspecified
487.0 Influenza, with pneumonia
041.3* *Klebsiella pneumoniae*
088.81 Lyme disease
084.6* Malaria
075 Mononucleosis
072.9* Mumps
041.81 *Mycoplasma*
041.2 *Pneumococcus*
041.6 *Proteus*
041.7 *Pseudomonas*
071 Rabies
056.9* Rubella
003.9* Salmonella
135 Sarcoidosis
004.9* Shigellosis

041.10* *Staphylococcus*
041.00* *Streptococcus*
097.9* Syphilis
082.9* Tick-borne rikettsiosis
130.9* Toxoplasmosis
124 Trichinosis
131.9* Trichomoniasis
002.0 Typhoid fever
081.9* Typhus

Overdose

Additional diagnostic codes for overdose/poisoning can be located in the Alphabetic Index (Volume 2) of ICD-9-CM in the table of drugs and chemicals, listed alphabetically by drug in the "Poisoning" column.

965.4 Acetaminophen
962.0 Adrenal cortical steroids
972.4 Amyl/butyl/nitrite
962.1 Androgens and anabolic steroids
971.1 Anticholinergics
969.0 Antidepressants
967.0 Barbiturates
969.4 Benzodiazepine-based tranquilizers
969.2 Butyrophenone-based tranquilizers
967.1 Chloral hydrate
968.5 Cocaine
967.5 Glutethimide
969.6 Hallucinogens/cannabis
962.3 Insulin and antidiabetic agents
967.4 Methaqualone
968.2 Nitrous oxide
970.1 Opioid antagonists
965.00 Opioids
967.2 Paraldehyde
968.3 Phencyclidine
969.1 Phenothiazine-based tranquilizers
965.1 Salicylates
970.9 Stimulants
962.7 Thyroid and thyroid derivatives

Additional Codes for Medication-Induced Disorders

The following are the ICD-9-CM codes for selected medications that may cause Substance-Induced Disorders. They are made available for optional use by clinicians in situations in which these medications, prescribed at therapeutic dose levels, have resulted in one of the following: Substance-Induced Delirium, Substance-Induced

Persisting Dementia, Substance-Induced Persisting Amnestic Disorder, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder, Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction, Substance-Induced Sleep Disorder, and Medication-Induced Movement Disorders. When used in multiaxial evaluation, the E-codes should be coded on Axis I immediately following the related disorder. It should be noted that these E-codes do not apply to poisonings or to a medication taken as an overdose.

Example:
292.39 Substance-Induced Mood Disorder, With Depressive Features
E932.2 Oral contraceptives

Analgesics and Antipyretics

E935.4 Acetaminophen/phenacetin
E935.1 Methadone
E935.6 Nonsteroidal anti-inflammatory agents
E935.2 Other narcotics (e.g., codeine, meperidine)
E935.3 Salicylates (e.g., aspirin)

Anticonvulsants

E936.3 Carbamazepine
E936.2 Ethosuximide
E937.0 Phenobarbital
E936.1 Phenytoin
E936.3 Valproic acid

Antiparkinsonian Medications

E936.4 Amantadine
E941.1 Benztropine
E933.0 Diphenhydramine
E936.4 L-Dopa

Neuroleptic Medications

E939.2 Butyrophenone-based neuroleptics (e.g., haloperidol)
E939.3 Other neuroleptics (e.g., thiothixene)
E939.1 Phenothiazine-based neuroleptics (e.g., chlorpromazine)

Sedatives, Hypnotics, and Anxiolytics

E937.0 Barbiturates
E939.4 Benzodiazepine-based medications
E937.1 Chloral hydrate
E939.5 Hydroxyzine
E937.2 Paraldehyde

Other Psychotropic Medications

E939.0 Antidepressants
E939.6 Cannabis
E940.1 Opioid antagonists
E939.7 Stimulants (excluding central appetite depressants)

Cardiovascular Medications

E942.0 Antiarrhythmic medication (includes propranolol)
E942.2 Antilipemic and cholesterol-lowering medication
E942.1 Cardiac glycosides (e.g., digitalis)
E942.4 Coronary vasodilators (e.g., nitrates)
E942.3 Ganglion-blocking agents (pentamethonium)
E942.6 Other antihypertensive agents (e.g., clonidine, guanethidine, reserpine)
E942.5 Other vasodilators (e.g., hydralazine)

Primarily Systemic Agents

E933.0 Antiallergic and antiemetic agents (excluding phenothiazines, hydroxyzine)
E941.1 Anticholinergics (e.g., atropine) and spasmolytics
E934.2 Anticoagulants
E933.1 Antineoplastic and immunosuppressive drugs
E941.0 Cholinergics (parasympathomimetics)
E941.2 Sympathomimetics (adrenergics)
E933.5 Vitamins (excluding vitamin K)

Medications Acting on Muscles and the Respiratory System

E945.7 Antiasthmatics (aminophylline)
E945.4 Antitussives (e.g., dextromethorphan)
E945.8 Other respiratory drugs
E945.0 Oxytocic agents (ergot alkaloids, prostaglandins)
E945.2 Skeletal muscle relaxants
E945.1 Smooth muscle relaxants (metaproterenol)

Hormones and Synthetic Substitutes

E932.0 Adrenal cortical steroids
E932.1 Anabolic steroids and androgens
E932.8 Antithyroid agents
E932.2 Ovarian hormones (includes oral contraceptives)
E932.7 Thyroid replacements

Diuretics and Mineral and Uric Acid Metabolism Drugs

E944.2 Carbonic acid anhydrase inhibitors
E944.3 Chlorthiazides
E944.0 Mercurial diuretics

E944.4 Other diuretics (furosemide, ethacrynic acid)
E944.1 Purine derivative diuretics
E944.7 Uric acid metabolism drugs (probenecid)

Appendix H

DSM-IV Classification (With ICD-10 Codes)

As of the publication of this text revision (in the late spring of 2000), the official coding system in use in the United States is the *International Classification of Diseases,* Ninth Revision, Clinical Modification (ICD-9-CM). Throughout much of the world, the official coding system is the *International Statistical Classification of Diseases and Related Health Problems,* Tenth Revision (ICD-10). The preparation of DSM-IV has been closely coordinated with the preparation of Chapter V, "Mental and Behavioural Disorders," of ICD-10 (developed by the World Health Organization in anticipation of its eventual implementation in the United States). Consultations between the American Psychiatric Association and the World Health Organization have resulted in DSM-IV codes and terms that are fully compatible with the codes and terms in the tabular index of ICD-10. To facilitate the use of DSM-IV internationally, presented below is the DSM-IV Classification with the ICD-10 codes.

NOS = Not Otherwise Specified.

An *x* appearing in a diagnostic code indicates that a specific code number is required.

An ellipsis (. . .) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., F05.0 Delirium Due to Hypothyroidism).

Numbers in parentheses are page numbers.

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

Mild
Moderate
Severe

If criteria are no longer met, one of the following specifiers may be noted:

In Partial Remission
In Full Remission
Prior History

Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (39)

MENTAL RETARDATION (41)

Note: *These are coded on Axis II.*

F70.9 Mild Mental Retardation (43)
F71 .9 Moderate Mental Retardation (43)
F72.9 Severe Mental Retardation (43)
F73.9 Profound Mental Retardation (44)
F79.9 Mental Retardation, Severity Unspecified (44)

LEARNING DISORDERS (49)

F81.0 Reading Disorder (51)
F81.2 Mathematics Disorder (53)
F81.8 Disorder of Written Expression (54)
F81.9 Learning Disorder NOS (56)

MOTOR SKILLS DISORDER (56)

F82 Developmental Coordination Disorder (56)

COMMUNICATION DISORDERS (58)

F80.1 Expressive Language Disorder (58)
F80.2 Mixed Receptive-Expressive Language Disorder (62)
F80.0 Phonological Disorder (65)
F98.5 Stuttering (67)
F80.9 Communication Disorder NOS (69)

PERVASIVE DEVELOPMENTAL DISORDERS (69)

F84.0 Autistic Disorder (70)
F84.2 Rett's Disorder (76)
F84.3 Childhood Disintegrative Disorder (77)
F84.5 Asperger's Disorder (80)
F84.9 Pervasive Developmental Disorder NOS (84)

ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS (85)

___._ Attention-Deficit/Hyperactivity Disorder (85)
F90.0 Combined Type
F98.8 Predominantly Inattentive Type
F90.0 Predominantly Hyperactive-Impulsive Type
F90.9 Attention-Deficit/Hyperactivity Disorder NOS (93)
F91.8 Conduct Disorder (93)
Specify type: Childhood-Onset Type/Adolescent-Onset Type
F91.3 Oppositional Defiant Disorder (100)
F91.9 Disruptive Behavior Disorder NOS (103)

FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD (103)

F98.3 Pica (103)
F98.2 Rumination Disorder (105)
F98.2 Feeding Disorder of Infancy or Early Childhood (107)

TIC DISORDERS (108)

F95.2 Tourette's Disorder (111)
F95.1 Chronic Motor or Vocal Tic Disorder (114)
F95.0 Transient Tic Disorder (115)
Specify if: Single Episode/Recurrent
F95.9 Tic Disorder NOS (116)

ELIMINATION DISORDERS (116)

__._ Encopresis (116)
R15 With Constipation and Overflow Incontinence *(also code K59.0 constipation on Axis III)*
F98.1 Without Constipation and Overflow Incontinence
F98.0 Enuresis (Not Due to a General Medical Condition) (118)
Specify type: Nocturnal Only/Diurnal Only/Nocturnal and Diurnal

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE (121)

F93.0 Separation Anxiety Disorder (121)
Specify if: Early Onset

F94.0 Selective Mutism (125)

F94.x Reactive Attachment Disorder of Infancy or Early Childhood (127)
.1 Inhibited Type
.2 Disinhibited Type

F98.4 Stereotypic Movement Disorder (131)
Specify if: With Self-Injurious Behavior

F98.9 Disorder of Infancy, Childhood, or Adolescence NOS (134)

Delirium, Dementia, and Amnestic and Other Cognitive Disorders (135)

DELIRIUM (136)

F05.0 Delirium Due to . . . *[Indicate the General Medical Condition] (code F05.1 if superimposed on Dementia)* (141)

___.__ Substance Intoxication Delirium *(refer to Substance-Related Disorders for substance-specific codes)* (143)

___.__ Substance Withdrawal Delirium *(refer to Substance-Related Disorders for substance-specific codes)* (143)

____.__ Delirium Due to Multiple Etiologies *(code each of the specific etiologies)* (146)

F05.9 Delirium NOS (147)

DEMENTIA (147)

F00.xx Dementia of the Alzheimer's Type, With Early Onset *(also code G30.0 Alzheimer's Disease, With Early Onset, on Axis III)* (154)
.00 Uncomplicated
.01 With Delusions
.03 With Depressed Mood
Specify if: With Behavioral Disturbance

F00.xx Dementia of the Alzheimer's Type, With Late Onset *(also code G30.1 Alzheimer's Disease, With Late Onset, on Axis III)* (154)
.10 Uncomplicated
.11 With Delusions
.13 With Depressed Mood
Specify if: With Behavioral Disturbance

F01.xx Vascular Dementia (158)
.80 Uncomplicated
.81 With Delusions
.83 With Depressed Mood
Specify if: With Behavioral Disturbance

F02.4 Dementia Due to HIV Disease *(also code B22.0 HIV disease resulting in encephalopathy on Axis III)* (163)

F02.8 Dementia Due to Head Trauma *(also code S06.9 Intracranial injury on Axis III)* (164)

F02.3 Dementia Due to Parkinson's Disease *(also code G20 Parkinson's disease on Axis III)* (164)

F02.2 Dementia Due to Huntington's Disease *(also code G10 Huntington's disease on Axis III)* (165)

F02.0 Dementia Due to Pick's Disease *(also code G31.0 Pick's disease on Axis III)* (165)

F02.1 Dementia Due to Creutzfeldt-Jakob Disease *(also code A81.0 Creutzfeldt-Jakob disease on Axis III)* (166)

F02.8 Dementia Due to . . . *[Indicate the General Medical Condition not listed above] (also code the general medical condition on Axis III)* (167)

___.__ Substance-Induced Persisting Dementia *(refer to Substance-Related Disorders for substance-specific codes)* (168)

F02.8 Dementia Due to Multiple Etiologies *(instead code F00.2 for mixed Alzheimer's and Vascular Dementia)* (170)

F03 Dementia NOS (171)

AMNESTIC DISORDERS (172)

F04 Amnestic Disorder Due to . . . *[Indicate the General Medical Condition]* (175)
Specify if: Transient/Chronic

___.__ Substance-Induced Persisting Amnestic Disorder (*refer to Substance-Related Disorders for substance-specific codes)* (177)

R41.3 Amnestic Disorder NOS (179)

OTHER COGNITIVE DISORDERS (179)

F06.9 Cognitive Disorder NOS (179)

Mental Disorders Due to a General Medical Condition Not Elsewhere Classified (181)

F06.1 Catatonic Disorder Due to . . . *[Indicate the General Medical Condition]* (185)

F07.0 Personality Change Due to . . . *[Indicate the General Medical Condition]* (187)
Specify type: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type

F09 Mental Disorder NOS Due to . . . *[Indicate the General Medical Condition]* (190)

Substance-Related Disorders (191)

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

Specify if: With Physiological Dependence/Without Physiological Dependence

Code course of Dependence in fifth character:

0 = Early Full Remission/Early Partial Remission
0 = Sustained Full Remission/Sustained Partial Remission
1 = In a Controlled Environment
2 = On Agonist Therapy
4 = Mild/Moderate/Severe

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

[I]With Onset During Intoxication/ [W]With Onset During Withdrawal

ALCOHOL-RELATED DISORDERS (21[illegible]

Alcohol Use Disorders (213)

F10.2x Alcohol Dependence[a] (213)

F10.1Alcohol Abuse (214)

Alcohol-Induced Disorders (214)

F10.00 Alcohol Intoxication (214)

F10.3 Alcohol Withdrawal (215)
Specify if: With Perceptual Disturbances

F10.03 Alcohol Intoxication Delirium (143)

F10.4 Alcohol Withdrawal Delirium (143)

F10.73 Alcohol-Induced Persisting Dementia (168)

F10.6 Alcohol-Induced Persisting Amnestic Disorder (177)

F10.xx Alcohol-Induced Psychotic Disorder (338)
.51 With Delusions[I,W]
.52 With Hallucinations[I,W]

F10.8 Alcohol-Induced Mood Disorder[I,W] (405)

F10.8 Alcohol-Induced Anxiety Disorder[I,W] (479)
F10.8 Alcohol-Induced Sexual Dysfunction[I] (562)
F10.8 Alcohol-Induced Sleep Disorder [I,W] (655)

F10.9 Alcohol-Related Disorder NOS (223)

AMPHETAMINE (OR AMPHETAMINE-LIKE)–RELATED DISORDERS (223)

Amphetamine Use Disorders (224)
F15.2x Amphetamine Dependence[a] (224)
F15.1 Amphetamine Abuse (225)

Amphetamine-Induced Disorders (226)
F15.00 Amphetamine Intoxication (226)
F15.04 Amphetamine Intoxication, With Perceptual Disturbances (226)
F15.3 Amphetamine Withdrawal (227)
F15.03 Amphetamine Intoxication Delirium (143)
F15.xx Amphetamine-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F15.8 Amphetamine-Induced Mood Disorder[I,W] (405)
F15.8 Amphetamine-Induced Anxiety Disorder[I] (479)
F15.8 Amphetamine-Induced Sexual Dysfunction[I] (562)
F15.8 Amphetamine-Induced Sleep Disorder[I,W] (655)

F15.9 Amphetamine-Related Disorder NOS (231)

CAFFEINE-RELATED DISORDERS (231)

Caffeine-Induced Disorders (232)
F15.00 Caffeine Intoxication (232)
F15.8 Caffeine-Induced Anxiety Disorder [I] (479)
F15.8 Caffeine-Induced Sleep Disorder[I] (655)

F15.9 Caffeine-Related Disorder NOS (234)

CANNABIS-RELATED DISORDERS (234)

Cannabis Use Disorders (236)
F12.2x Cannabis Dependence[a] (236)
F12.1 Cannabis Abuse (236)

Cannabis-Induced Disorders (237)
F12.00 Cannabis Intoxication (237)
F12.04 Cannabis Intoxication, With Perceptual Disturbances (237)
F12.03 Cannabis Intoxication Delirium (143)
F12.xx Cannabis-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F12.8 Cannabis-Induced Anxiety Disorder[I] (479)

F12.9 Cannabis-Related Disorder NOS (241)

COCAINE-RELATED DISORDERS (241)

Cocaine Use Disorders (242)
F14.2x Cocaine Dependence[a] (242)
F14.1 Cocaine Abuse (243)

Cocaine-Induced Disorders (244)
F14.00 Cocaine Intoxication (244)
F14.04 Cocaine Intoxication, With Perceptual Disturbances (244)
F14.3 Cocaine Withdrawal (245)
F14.03 Cocaine Intoxication Delirium (143)
F14.xx Cocaine-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F14.8 Cocaine-Induced Mood Disorder[I,W] (405)
F14.8 Cocaine-Induced Anxiety Disorder[I,W] (479)
F14.8 Cocaine-Induced Sexual Dysfunction[I] (562)

F14.8 Cocaine-Induced Sleep Disorder[I,W] (655)

F14.9 Cocaine-Related Disorder NOS (250)

HALLUCINOGEN-RELATED DISORDERS (250)

Hallucinogen Use Disorders (251)
F16.2x Hallucinogen Dependence[a] (251)
F16.1 Hallucinogen Abuse (252)

Hallucinogen-Induced Disorders (252)
F16.00 Hallucinogen Intoxication (252)
F16.70 Hallucinogen Persisting Perception Disorder (Flashbacks) (253)
F16.03 Hallucinogen Intoxication Delirium (143)
F16.xx Hallucinogen-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F16.8 Hallucinogen-Induced Mood Disorder[I] (405)
F16.8 Hallucinogen-Induced Anxiety Disorder[I] (479)

F16.9 Hallucinogen-Related Disorder NOS (256)

INHALANT-RELATED DISORDERS (257)

Inhalant Use Disorders (258)
F18.2x Inhalant Dependence[a] (258)
F18.1 Inhalant Abuse (259)

Inhalant-Induced Disorders (259)
F18.00 Inhalant Intoxication (259)
F18.03 Inhalant Intoxication Delirium (143)
F18.73 Inhalant-Induced Persisting Dementia (168)
F18.xx Inhalant-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F18.8 Inhalant-Induced Mood Disorder[I] (405)
F18.8 Inhalant-Induced Anxiety Disorder[I] (479)

F18.9 Inhalant-Related Disorder NOS (263)

NICOTINE-RELATED DISORDERS (264)

Nicotine Use Disorder (264)
F17.2x Nicotine Dependence[a] (264)

Nicotine-Induced Disorder (265)
F17.3 Nicotine Withdrawal (265)

F17.9 Nicotine-Related Disorder NOS (269)

OPIOID-RELATED DISORDERS (269)

Opioid Use Disorders (270)
F11.2x Opioid Dependence[a] (270)
F11.1 Opioid Abuse (271)

Opioid-Induced Disorders (271)
F11.00 Opioid Intoxication (271)
F11.04 Opioid Intoxication, With Perceptual Disturbances (272)
F11.3 Opioid Withdrawal (272)
F11.03 Opioid Intoxication Delirium (143)
F11.xx Opioid-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F11.8 Opioid-Induced Mood Disorder[I] (405)
F11.8 Opioid-Induced Sexual Dysfunction[I] (562)
F11.8 Opioid-Induced Sleep Disorder[I,W] (655)

F11.9 Opioid-Related Disorder NOS (277)

PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)–RELATED DISORDERS (278)

Phencyclidine Use Disorders (279)
F19.2x Phencyclidine Dependence[a] (279)
F19.1 Phencyclidine Abuse (279)

Phencyclidine-Induced Disorders (280)

F19.00 Phencyclidine Intoxication (280)
F19.04 Phencyclidine Intoxication, With Perceptual Disturbances (280)
F19.03 Phencyclidine Intoxication Delirium (143)
F19.xx Phencyclidine-Induced Psychotic Disorder (338)
.51 With Delusions[I]
.52 With Hallucinations[I]
F19.8 Phencyclidine-Induced Mood Disorder[I] (405)
F19.8 Phencyclidine-Induced Anxiety Disorder[I] (479)
F19.9 Phencyclidine-Related Disorder NOS (283)

SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS (284)

Sedative, Hypnotic, or Anxiolytic Use Disorders (285)

F13.2x Sedative, Hypnotic, or Anxiolytic Dependence[a] (285)
F13.1 Sedative, Hypnotic, or Anxiolytic Abuse (286)

Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (286)

F13.00 Sedative, Hypnotic, or Anxiolytic Intoxication (286)
F13.3 Sedative, Hypnotic, or Anxiolytic Withdrawal (287)
Specify if: With Perceptual Disturbances
F13.03 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (143)
F13.4 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (143)
F13.73 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (168)
F13.6 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder (177)
F13.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder (338)
.51 With Delusions[I,W]
.52 With Hallucinations[I,W]
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W] (405)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W] (479)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I] (562)
F13.8 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W] (655)
F13.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS (293)

POLYSUBSTANCE-RELATED DISORDER (293)

F19.2x Polysubstance Dependence[a] (293)

OTHER (OR UNKNOWN) SUBSTANCE–RELATED DISORDERS (294)

Other (or Unknown) Substance Use Disorders (294)

F19.2x Other (or Unknown) Substance Dependence[a] (192)
F19.1 Other (or Unknown) Substance Abuse (198)

Other (or Unknown) Substance–Induced Disorders (295)

F19.00 Other (or Unknown) Substance Intoxication (199)
F19.04 Other (or Unknown) Substance Intoxication, With Perceptual Disturbances (199)
F19.3 Other (or Unknown) Substance Withdrawal (201)
Specify if: With Perceptual Disturbances

F19.03 Other (or Unknown) Substance–Induced Delirium *(code F19.4 if onset during withdrawal)* (143)

F19.73 Other (or Unknown) Substance–Induced Persisting Dementia (168)

F19.6 Other (or Unknown) Substance–Induced Persisting Amnestic Disorder (177)

F19.xx Other (or Unknown) Substance–Induced Psychotic Disorder (338)

.51 With Delusions[I,W]

.52 With Hallucinations[I,W]

F19.8 Other (or Unknown) Substance–Induced Mood Disorder[I,W] (405)

F19.8 Other (or Unknown) Substance–Induced Anxiety Disorder[I,W] (479)

F19.8 Other (or Unknown) Substance–Induced Sexual Dysfunction[I] (562)

F19.8 Other (or Unknown) Substance–Induced Sleep Disorder[I,W] (655)

F19.9 Other (or Unknown) Substance–Related Disorder NOS (295)

Schizophrenia and Other Psychotic Disorders (297)

F20.xx Schizophrenia (298)

.0x Paranoid Type (313)

.1x Disorganized Type (314)

.2x Catatonic Type (315)

.3x Undifferentiated Type (316)

.5x Residual Type (316)

Code course of Schizophrenia in fifth character:

2 = Episodic With Interepisode Residual Symptoms (*specify if:* With Prominent Negative Symptoms)

3 = Episodic With No Interepisode Residual Symptoms

0 = Continuous (*specify if:* With Prominent Negative Symptoms)

4 = Single Episode In Partial Remission (*specify if:* With Prominent Negative Symptoms)

5 = Single Episode In Full Remission

8 = Other or Unspecified Pattern

9 = Less than 1 year since onset of initial active-phase symptoms

F20.8 Schizophreniform Disorder (317)
Specify if: Without Good Prognostic Features/With Good Prognostic Features

F25.x Schizoaffective Disorder (319)

.0 Bipolar Type

.1 Depressive Type

F22.0 Delusional Disorder (323)
Specify type: Erotomanic Type/Grandiose Type/Jealous Type/Persecutory Type/Somatic Type/Mixed Type/Unspecified Type

F23.xx Brief Psychotic Disorder (329)

.81 With Marked Stressor(s)

.80 Without Marked Stressor(s)
Specify if: With Postpartum Onset

F24 Shared Psychotic Disorder (332)

F06.x Psychotic Disorder Due to . . . *[Indicate the General Medical Condition]* (334)

.2 With Delusions

.0 With Hallucinations

—.— Substance-Induced Psychotic Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (338)
Specify if: With Onset During Intoxication/With Onset During Withdrawal

F29 Psychotic Disorder NOS (343)

Mood Disorders (345)

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

[a]Severity/Psychotic/Remission Specifiers/ [b]Chronic/[c]With Catatonic Features/[d]With Melancholic Features/[e]With Atypical Features/[f]With Postpartum Onset

The following specifiers apply to Mood Disorders as noted:

[g]With or Without Full Interepisode Recovery/ [h]With Seasonal Pattern/[i]With Rapid Cycling

DEPRESSIVE DISORDERS (369)

F32.x Major Depressive Disorder, Single Episode[a,b,c,d,e,f] (369)

F33.x Major Depressive Disorder, Recurrent[a,b,c,d,e,f,g,h] (369)

Code current state of Major Depressive Episode in fourth character:

0 = Mild
1 = Moderate
2 = Severe Without Psychotic Features
3 = Severe With Psychotic Features
Specify: Mood-Congruent Psychotic Features/Mood-Incongruent Psychotic Features
4 = In Partial Remission
4 = In Full Remission
9 = Unspecified

F34.1 Dysthymic Disorder (376)
Specify if: Early Onset/Late Onset
Specify: With Atypical Features

F32.9 Depressive Disorder NOS (381)

BIPOLAR DISORDERS (382)

F30.x Bipolar I Disorder, Single Manic Episode[a,c,f] (382)
Specify if: Mixed

Code current state of Manic Episode in fourth character:

1 = Mild, Moderate, or Severe Without Psychotic Features
2 = Severe With Psychotic Features
8 = In Partial or Full Remission

F31.0 Bipolar I Disorder, Most Recent Episode Hypomanic[g,h,i] (382)

F31.x Bipolar I Disorder, Most Recent Episode Manic[a,c,f,g,h,i] (382)

Code current state of Manic Episode in fourth character:

1 = Mild, Moderate, or Severe Without Psychotic Features
2 = Severe With Psychotic Features
7 = In Partial or Full Remission

F31.6 Bipolar I Disorder, Most Recent Episode Mixed[a,c,f,g,h,i] (382)

F31.x Bipolar I Disorder, Most Recent Episode Depressed[a,b,c,d,e,f,g,h,i] (382)

Code current state of Major Depressive Episode in fourth character:

3 = Mild or Moderate
4 = Severe Without Psychotic Features
5 = Severe With Psychotic Features
7 = In Partial or Full Remission

F31.9 Bipolar I Disorder, Most Recent Episode Unspecified[g,h,i] (382)

F31.8 Bipolar II Disorder[a,b,c,d,e,f,g,h,i] (392)
Specify (current or most recent episode): Hypomanic/Depressed

F34.0 Cyclothymic Disorder (398)

F31.9 Bipolar Disorder NOS (400)

F06.xx Mood Disorder Due to . . . *[Indicate the General Medical Condition]* (401)
.32 With Depressive Features
.32 With Major Depressive–Like Episode
.30 With Manic Features
.33 With Mixed Features

___.__ Substance-Induced Mood Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (405)
Specify type: With Depressive Features/With Manic Features/With Mixed Features
Specify if: With Onset During Intoxication/With Onset During Withdrawal

F39 Mood Disorder NOS (410)

Anxiety Disorders (429)

F41.0 Panic Disorder Without Agoraphobia (433)
F40.01 Panic Disorder With Agoraphobia (433)
F40.00 Agoraphobia Without History of Panic Disorder (441)
F40.2 Specific Phobia (443)
Specify type: Animal Type/Natural Environment Type/Blood-Injection-Injury Type/Situational Type/Other Type
F40.1 Social Phobia (450)
Specify if: Generalized
F42.8 Obsessive-Compulsive Disorder (456)
Specify if: With Poor Insight
F43.1 Posttraumatic Stress Disorder (463)
Specify if: Acute/Chronic
Specify if: With Delayed Onset
F43.0 Acute Stress Disorder (469)
F41.1 Generalized Anxiety Disorder (472)
F06.4 Anxiety Disorder Due to . . . *[Indicate the General Medical Condition]* (476)
Specify if: With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms
___._ Substance-Induced Anxiety Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (479)
Specify if: With Generalized Anxiety/With Panic Attacks/With Obsessive-Compulsive Symptoms/With Phobic Symptoms
Specify if: With Onset During Intoxication/With Onset During Withdrawal
F41.9 Anxiety Disorder NOS (484)

Somatoform Disorders (485)

F45.0 Somatization Disorder (486)
F45.1 Undifferentiated Somatoform Disorder (490)
F44.x Conversion Disorder (492)
.4 With Motor Symptom or Deficit
.5 With Seizures or Convulsions
.6 With Sensory Symptom or Deficit
.7 With Mixed Presentation
F45.4 Pain Disorder (498)
Specify type: Associated With Psychological Factors/Associated W Both Psychological Factors and a General Medical Condition
Specify if: Acute/Chronic
F45.2 Hypochondriasis (504)
Specify if: With Poor Insight
F45.2 Body Dysmorphic Disorder (507)
F45.9 Somatoform Disorder NOS (511

Factitious Disorders (513)

F68.1 Factitious Disorder (513)
Specify type: With Predominantly Psychological Signs and Symptoms/With Predominantly Physical Signs and Symptoms/With Combined Psychological and Physical Signs and Symptoms
F68.1 Factitious Disorder NOS (517)

Dissociative Disorders (519)

F44.0 Dissociative Amnesia (520)
F44.1 Dissociative Fugue (523)

F44.81 Dissociative Identity Disorder (526)
F48.1 Depersonalization Disorder (530)
F44.9 Dissociative Disorder NOS (532)

Sexual and Gender Identity Disorders (535)

SEXUAL DYSFUNCTIONS (535)

The following specifiers apply to all primary Sexual Dysfunctions:

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

Sexual Desire Disorders (539)

F52.0 Hypoactive Sexual Desire Disorder (539)
F52.10 Sexual Aversion Disorder (541)

Sexual Arousal Disorders (543)

F52.2 Female Sexual Arousal Disorder (543)
F52.2 Male Erectile Disorder (545)

Orgasmic Disorders (547)

F52.3 Female Orgasmic Disorder (547)
F52.3 Male Orgasmic Disorder (550)
F52.4 Premature Ejaculation (552)

Sexual Pain Disorders (554)

F52.6 Dyspareunia (Not Due to a General Medical Condition) (554)
F52.5 Vaginismus (Not Due to a General Medical Condition) (556)

Sexual Dysfunction Due to a General Medical Condition (558)

N94.8 Female Hypoactive Sexual Desire Disorder Due to . . . [*Indicate the General Medical Condition]* (558)
N50.8 Male Hypoactive Sexual Desire Disorder Due to . . . [*Indicate the General Medical Condition]* (558)
N48.4 Male Erectile Disorder Due to . . . [*Indicate the General Medical Condition]* (558)
N94.1 Female Dyspareunia Due to . . . *[Indicate the General Medical Condition]* (558)
N50.8 Male Dyspareunia Due to . . . *[Indicate the General Medical Condition]* (558)
N94.8 Other Female Sexual Dysfunction Due to . . . *[Indicate the General Medical Condition]* (558)
N50.8 Other Male Sexual Dysfunction Due to . . . [*Indicate the General Medical Condition]* (558)

——.– Substance-Induced Sexual Dysfunction *(refer to Substance-Related Disorders for substance-specific codes)* (562)
Specify if: With Impaired Desire/With Impaired Arousal/With Impaired Orgasm/With Sexual Pain
Specify if: With Onset During Intoxication

F52.9 Sexual Dysfunction NOS (565)

PARAPHILIAS (566)

F65.2 Exhibitionism (569)
F65.0 Fetishism (569)
F65.8 Frotteurism (570)
F65.4 Pedophilia (571)
Specify if: Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both
Specify if: Limited to Incest
Specify type: Exclusive Type/Nonexclusive Type
F65.5 Sexual Masochism (572)
F65.5 Sexual Sadism (573)
F65.1 Transvestic Fetishism (574)
Specify if: With Gender Dysphoria
F65.3 Voyeurism (575)
F65.9 Paraphilia NOS (576)

GENDER IDENTITY DISORDERS (576)

F64.x Gender Identity Disorder (576)
- .2 in Children
- .0 in Adolescents or Adults

Specify if: Sexually Attracted to Males/Sexually Attracted to Females/Sexually Attracted to Both/Sexually Attracted to Neither

F64.9 Gender Identity Disorder NOS (582)

F52.9 Sexual Disorder NOS (582)

Eating Disorders (583)

F50.0 Anorexia Nervosa (583)
Specify type: Restricting Type; Binge-Eating/Purging Type

F50.2 Bulimia Nervosa (589)
Specify type: Purging Type/Nonpurging Type

F50.9 Eating Disorder NOS (594)

Sleep Disorders (597)

PRIMARY SLEEP DISORDERS (598)

Dyssomnias (598)

F51.0 Primary Insomnia (599)

F51.1 Primary Hypersomnia (604)
Specify if: Recurrent

G47.4 Narcolepsy (609)

G47.3 Breathing-Related Sleep Disorder (615)

F51.2 Circadian Rhythm Sleep Disorder (622)
Specify type: Delayed Sleep Phase Type/Jet Lag Type/Shift Work Type/Unspecified Type

F51.9 Dyssomnia NOS (629)

Parasomnias (630)

F51.5 Nightmare Disorder (631)

F51.4 Sleep Terror Disorder (634)

F51.3 Sleepwalking Disorder (639)

F51.8 Parasomnia NOS (644)

SLEEP DISORDERS RELATED TO ANOTHER MENTAL DISORDER (645)

F51.0 Insomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]* (645)

F51.1 Hypersomnia Related to . . . *[Indicate the Axis I or Axis II Disorder]* (645)

OTHER SLEEP DISORDERS (651)

G47.x Sleep Disorder Due to . . . *[Indicate the General Medical Condition]* (651)
- .0 Insomnia Type
- .1 Hypersomnia Type
- .8 Parasomnia Type
- .8 Mixed Type

—.– Substance-Induced Sleep Disorder *(refer to Substance-Related Disorders for substance-specific codes)* (655)
Specify type: Insomnia Type/Hypersomnia Type/Parasomnia Type/Mixed Type
Specify if: With Onset During Intoxication/With Onset During Withdrawal

Impulse-Control Disorders Not Elsewhere Classified (663)

F63.8 Intermittent Explosive Disorder (663)

F63.2 Kleptomania (667)

F63.1 Pyromania (669)

F63.0 Pathological Gambling (671)

F63.3 Trichotillomania (674)

F63.9 Impulse-Control Disorder NOS (677)

Adjustment Disorders (679)

F43.xx Adjustment Disorder (679)
- .20 With Depressed Mood
- .28 With Anxiety
- .22 With Mixed Anxiety and Depressed Mood
- .24 With Disturbance of Conduct
- .25 With Mixed Disturbance of Emotions and Conduct
- .9 Unspecified

Specify if: Acute/Chronic

Personality Disorders (685)

Note: *These are coded on Axis II.*

F60.0 Paranoid Personality Disorder (690)
F60.1 Schizoid Personality Disorder (694)
F21 Schizotypal Personality Disorder (697)
F60.2 Antisocial Personality Disorder (701)
F60.31 Borderline Personality Disorder (706)
F60.4 Histrionic Personality Disorder (711)
F60.8 Narcissistic Personality Disorder (714)
F60.6 Avoidant Personality Disorder (718)
F60.7 Dependent Personality Disorder (721)
F60.5 Obsessive-Compulsive Personality Disorder (725)
F60.9 Personality Disorder NOS (729)

Other Conditions That May Be a Focus of Clinical Attention (731)

PSYCHOLOGICAL FACTORS AFFECTING MEDICAL CONDITION (731)

F54 . . . *[Specified Psychological Factor]* Affecting . . . *[Indicate the General Medical Condition]*
Choose name based on nature of factors: (731)
- Mental Disorder Affecting Medical Condition
- Psychological Symptoms Affecting Medical Condition
- Personality Traits or Coping Style Affecting Medical Condition
- Maladaptive Health Behaviors Affecting Medical Condition
- Stress-Related Physiological Response Affecting Medical Condition
- Other or Unspecified Psychological Factors Affecting Medical Condition

MEDICATION-INDUCED MOVEMENT DISORDERS (734)

G21.0 Neuroleptic-Induced Parkinsonism (735)
G21.0 Neuroleptic Malignant Syndrome (735)
G24.0 Neuroleptic-Induced Acute Dystonia (735)
G21.1 Neuroleptic-Induced Acute Akathisia (735)
G24.0 Neuroleptic-Induced Tardive Dyskinesia (736)
G25.1 Medication-Induced Postural Tremor (736)
G25.9 Medication-Induced Movement Disorder NOS (736)

OTHER MEDICATION-INDUCED DISORDER (736)

T88.7 Adverse Effects of Medication NOS (736)

RELATIONAL PROBLEMS (736)

Z63.7 Relational Problem Related to a Mental Disorder or General Medical Condition (737)
Z63.8 Parent-Child Relational Problem *(code Z63.1 if focus of attention is on child)* (737)
Z63.0 Partner Relational Problem (737)
F93.3 Sibling Relational Problem (737)
Z63.9 Relational Problem NOS (737)

PROBLEMS RELATED TO ABUSE OR NEGLECT (738)

T74.1 Physical Abuse of Child (738)
T74.2 Sexual Abuse of Child (738)
T74.0 Neglect of Child (738)
T74.1 Physical Abuse of Adult (738)
T74.2 Sexual Abuse of Adult (738)

ADDITIONAL CONDITIONS THAT MAY BE A FOCUS OF CLINICAL ATTENTION (739)

Z91.1 Noncompliance With Treatment (739)
Z76.5 Malingering (739)
Z72.8 Adult Antisocial Behavior (740)
Z72.8 Child or Adolescent Antisocial Behavior (740)
R41.8 Borderline Intellectual Functioning (740)
R41.8 Age-Related Cognitive Decline (740)
Z63.4 Bereavement (740)
Z55.8 Academic Problem (741)
Z56.7 Occupational Problem (741)
F93.8 Identity Problem (741)
Z71.8 Religious or Spiritual Problem (741)
Z60.3 Acculturation Problem (741)
Z60.0 Phase of Life Problem (742)

Additional Codes (743)

F99 Unspecified Mental Disorder (nonpsychotic) (743)
Z03.2 No Diagnosis or Condition on Axis I (743)
R69 Diagnosis or Condition Deferred on Axis I (743)
Z03.2 No Diagnosis on Axis II (743)
R46.8 Diagnosis Deferred on Axis II (743)

Appendix I

Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes

This appendix is divided into two sections. The first section provides an outline for cultural formulation designed to assist the clinician in systematically evaluating and reporting the impact of the individual's cultural context. The second is a glossary of culture-bound syndromes.

Outline for Cultural Formulation

The following outline for cultural formulation is meant to supplement the multiaxial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment. The cultural formulation provides a systematic review of the individual's cultural background, the role of the cultural context in the expression and evaluation of symptoms and dysfunction, and the effect that cultural differences may have on the relationship between the individual and the clinician.

As indicated in the introduction to the manual (see p. xxxiii), it is important that the clinician take into account the individual's ethnic and cultural context in the evaluation of each of the DSM-IV axes. In addition, the cultural formulation suggested below provides an opportunity to describe systematically the individual's cultural and social reference group and ways in which the cultural context is relevant to clinical care. The clinician may provide a narrative summary for each of the following categories:

Cultural identity of the individual. Note the individual's ethnic or cultural reference groups. For immigrants and ethnic minorities, note separately the degree of involvement with both the culture of origin and the host culture (where applicable). Also note language abilities, use, and preference (including multilingualism).

Cultural explanations of the individual's illness. The following may be identified: the predominant idioms of distress through which symptoms or the need for social support are communicated (e.g., "nerves," possessing spirits, somatic complaints, inexplicable misfortune), the meaning and perceived severity of the individual's symp-

toms in relation to norms of the cultural reference group, any local illness category used by the individual's family and community to identify the condition (see "Glossary of Culture-Bound Syndromes" below), the perceived causes or explanatory models that the individual and the reference group use to explain the illness, and current preferences for and past experiences with professional and popular sources of care.

Cultural factors related to psychosocial environment and levels of functioning. Note culturally relevant interpretations of social stressors, available social supports, and levels of functioning and disability. This would include stresses in the local social environment and the role of religion and kin networks in providing emotional, instrumental, and informational support.

Cultural elements of the relationship between the individual and the clinician. Indicate differences in culture and social status between the individual and the clinician and problems that these differences may cause in diagnosis and treatment (e.g., difficulty in communicating in the individual's first language, in eliciting symptoms or understanding their cultural significance, in negotiating an appropriate relationship or level of intimacy, in determining whether a behavior is normative or pathological).

Overall cultural assessment for diagnosis and care. The formulation concludes with a discussion of how cultural considerations specifically influence comprehensive diagnosis and care.

Glossary of Culture-Bound Syndromes

The term *culture-bound syndrome* denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may or may not be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be "illnesses," or at least afflictions, and most have local names. Although presentations conforming to the major DSM-IV categories can be found throughout the world, the particular symptoms, course, and social response are very often influenced by local cultural factors. In contrast, culture-bound syndromes are generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.

There is seldom a one-to-one equivalence of any culture-bound syndrome with a DSM diagnostic entity. Aberrant behavior that might be sorted by a diagnostician using DSM-IV into several categories may be included in a single folk category, and presentations that might be considered by a diagnostician using DSM-IV as belonging to a single category may be sorted into several by an indigenous clinician. Moreover, some conditions and disorders have been conceptualized as culture-bound syndromes specific to industrialized culture (e.g., Anorexia Nervosa, Dissociative Identity Disorder), given their apparent rarity or absence in other cultures. It should also be noted that all industrialized societies include distinctive subcultures and widely diverse immigrant groups who may present with culture-bound syndromes.

This glossary lists some of the best-studied culture-bound syndromes and idioms of distress that may be encountered in clinical practice in North America and includes relevant DSM-IV categories when data suggest that they should be considered in a diagnostic formulation.

amok A dissociative episode characterized by a period of brooding followed by an outburst of violent, aggressive, or homicidal behavior directed at people and objects. The episode tends to be precipitated by a perceived slight or insult and seems to be prevalent only among males. The episode is often accompanied by persecutory ideas, automatism, amnesia, exhaustion, and a return to premorbid state following the episode. Some instances of amok may occur during a brief psychotic episode or constitute the onset or an exacerbation of a chronic psychotic process. The original reports that used this term were from Malaysia. A similar behavior pattern is found in Laos, Philippines, Polynesia (*cafard* or *cathard*), Papua New Guinea, and Puerto Rico (*mal de pelea*), and among the Navajo (*iich'aa*).

ataque de nervios An idiom of distress principally reported among Latinos from the Caribbean but recognized among many Latin American and Latin Mediterranean groups. Commonly reported symptoms include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal or physical aggression. Dissociative experiences, seizurelike or fainting episodes, and suicidal gestures are prominent in some attacks but absent in others. A general feature of an ataque de nervios is a sense of being out of control. Ataques de nervios frequently occur as a direct result of a stressful event relating to the family (e.g., news of the death of a close relative, a separation or divorce from a spouse, conflicts with a spouse or children, or witnessing an accident involving a family member). People may experience amnesia for what occurred during the ataque de nervios, but they otherwise return rapidly to their usual level of functioning. Although descriptions of some ataques de nervios most closely fit with the DSM-IV description of Panic Attacks, the association of most ataques with a precipitating event and the frequent absence of the hallmark symptoms of acute fear or apprehension distinguish them from Panic Disorder. Ataques span the range from normal expressions of distress not associated with having a mental disorder to symptom presentations associated with the diagnoses of Anxiety, Mood, Dissociative, or Somatoform Disorders.

bilis and **colera** (also referred to as *muina*) The underlying cause of these syndromes is thought to be strongly experienced anger or rage. Anger is viewed among many Latino groups as a particularly powerful emotion that can have direct effects on the body and can exacerbate existing symptoms. The major effect of anger is to disturb core body balances (which are understood as a balance between hot and cold valences in the body and between the material and spiritual aspects of the body). Symptoms can include acute nervous tension, headache, trembling, screaming, stomach disturbances, and, in more severe cases, loss of consciousness. Chronic fatigue may result from the acute episode.

boufée delirante A syndrome observed in West Africa and Haiti. This French term refers to a sudden outburst of agitated and aggressive behavior, marked confusion,

and psychomotor excitement. It may sometimes be accompanied by visual and auditory hallucinations or paranoid ideation. These episodes may resemble an episode of Brief Psychotic Disorder.

brain fag A term initially used in West Africa to refer to a condition experienced by high school or university students in response to the challenges of schooling. Symptoms include difficulties in concentrating, remembering, and thinking. Students often state that their brains are "fatigued." Additional somatic symptoms are usually centered around the head and neck and include pain, pressure or tightness, blurring of vision, heat, or burning. "Brain tiredness" or fatigue from "too much thinking" is an idiom of distress in many cultures, and resulting syndromes can resemble certain Anxiety, Depressive, and Somatoform Disorders.

dhat A folk diagnostic term used in India to refer to severe anxiety and hypochondriacal concerns associated with the discharge of semen, whitish discoloration of the urine, and feelings of weakness and exhaustion. Similar to *jiryan* (India), *sukra prameha* (Sri Lanka), and *shen-k'uei* (China).

falling-out or **blacking out** These episodes occur primarily in southern United States and Caribbean groups. They are characterized by a sudden collapse, which sometimes occurs without warning but sometimes is preceded by feelings of dizziness or "swimming" in the head. The individual's eyes are usually open but the person claims an inability to see. The person usually hears and understands what is occurring around him or her but feels powerless to move. This may correspond to a diagnosis of Conversion Disorder or a Dissociative Disorder.

ghost sickness A preoccupation with death and the deceased (sometimes associated with witchcraft) frequently observed among members of many American Indian tribes. Various symptoms can be attributed to ghost sickness, including bad dreams, weakness, feelings of danger, loss of appetite, fainting, dizziness, fear, anxiety, hallucinations, loss of consciousness, confusion, feelings of futility, and a sense of suffocation.

hwa-byung (also known as **wool-hwa-byung**) A Korean folk syndrome literally translated into English as "anger syndrome" and attributed to the suppression of anger. The symptoms include insomnia, fatigue, panic, fear of impending death, dysphoric affect, indigestion, anorexia, dyspnea, palpitations, generalized aches and pains, and a feeling of a mass in the epigastrium.

koro A term, probably of Malaysian origin, that refers to an episode of sudden and intense anxiety that the penis (or, in females, the vulva and nipples) will recede into the body and possibly cause death. The syndrome is reported in south and east Asia, where it is known by a variety of local terms, such as *shuk yang*, *shook yong*, and *suo yang* (Chinese); *jinjinia bemar* (Assam); or *rok-joo* (Thailand). It is occasionally found in the West. Koro at times occurs in localized epidemic form in east Asian areas. This diagnosis is included in the *Chinese Classification of Mental Disorders*, Second Edition (CCMD-2).

latah Hypersensitivity to sudden fright, often with echopraxia, echolalia, command obedience, and dissociative or trancelike behavior. The term *latah* is of Malaysian or Indonesian origin, but the syndrome has been found in many parts of the world. Other terms for this condition are *amurakh, irkunii, ikota, olan, myriachit,* and *menkeiti* (Siberian groups); *bah tschi, bah-tsi,* and *baah-ji* (Thailand); *imu* (Ainu, Sakhalin, Japan); and *mali-mali* and *silok* (Philippines). In Malaysia it is more frequent in middle-aged women.

locura A term used by Latinos in the United States and Latin America to refer to a severe form of chronic psychosis. The condition is attributed to an inherited vulnerability, to the effect of multiple life difficulties, or to a combination of both factors. Symptoms exhibited by persons with locura include incoherence, agitation, auditory and visual hallucinations, inability to follow rules of social interaction, unpredictability, and possible violence.

mal de ojo A concept widely found in Mediterranean cultures and elsewhere in the world. *Mal de ojo* is a Spanish phrase translated into English as "evil eye." Children are especially at risk. Symptoms include fitful sleep, crying without apparent cause, diarrhea, vomiting, and fever in a child or infant. Sometimes adults (especially females) have the condition.

nervios A common idiom of distress among Latinos in the United States and Latin America. A number of other ethnic groups have related, though often somewhat distinctive, ideas of "nerves" (such as *nevra* among Greeks in North America). Nervios refers both to a general state of vulnerability to stressful life experiences and to a syndrome brought on by difficult life circumstances. The term *nervios* includes a wide range of symptoms of emotional distress, somatic disturbance, and inability to function. Common symptoms include headaches and "brain aches," irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations). Nervios tends to be an ongoing problem, although variable in the degree of disability manifested. Nervios is a very broad syndrome that spans the range from cases free of a mental disorder to presentations resembling Adjustment, Anxiety, Depressive, Dissociative, Somatoform, or Psychotic Disorders. Differential diagnosis will depend on the constellation of symptoms experienced, the kind of social events that are associated with the onset and progress of nervios, and the level of disability experienced.

pibloktoq An abrupt dissociative episode accompanied by extreme excitement of up to 30 minutes' duration and frequently followed by convulsive seizures and coma lasting up to 12 hours. This is observed primarily in arctic and subarctic Eskimo communities, although regional variations in name exist. The individual may be withdrawn or mildly irritable for a period of hours or days before the attack and will typically report complete amnesia for the attack. During the attack, the individual may tear off his or her clothing, break furniture, shout obscenities, eat feces, flee from protective shelters, or perform other irrational or dangerous acts.

qi-gong psychotic reaction A term describing an acute, time-limited episode characterized by dissociative, paranoid, or other psychotic or nonpsychotic symptoms that may occur after participation in the Chinese folk health-enhancing practice of qi-gong ("exercise of vital energy"). Especially vulnerable are individuals who become overly involved in the practice. This diagnosis is included in the *Chinese Classification of Mental Disorders*, Second Edition (CCMD-2).

rootwork A set of cultural interpretations that ascribe illness to hexing, witchcraft, sorcery, or the evil influence of another person. Symptoms may include generalized anxiety and gastrointestinal complaints (e.g., nausea, vomiting, diarrhea), weakness, dizziness, the fear of being poisoned, and sometimes fear of being killed ("voodoo death"). "Roots," "spells," or "hexes" can be "put" or placed on other persons, causing a variety of emotional and psychological problems. The "hexed" person may even fear death until the "root" has been "taken off" (eliminated), usually through the work of a "root doctor" (a healer in this tradition), who can also be called on to bewitch an enemy. "Rootwork" is found in the southern United States among both African American and European American populations and in Caribbean societies. It is also known as *mal puesto* or *brujeria* in Latino societies.

sangue dormido ("sleeping blood") This syndrome is found among Portuguese Cape Verde Islanders (and immigrants from there to the United States) and includes pain, numbness, tremor, paralysis, convulsions, stroke, blindness, heart attack, infection, and miscarriage.

shenjing shuairuo ("neurasthenia") In China, a condition characterized by physical and mental fatigue, dizziness, headaches, other pains, concentration difficulties, sleep disturbance, and memory loss. Other symptoms include gastrointestinal problems, sexual dysfunction, irritability, excitability, and various signs suggesting disturbance of the autonomic nervous system. In many cases, the symptoms would meet the criteria for a DSM-IV Mood or Anxiety Disorder. This diagnosis is included in the *Chinese Classification of Mental Disorders*, Second Edition (CCMD-2).

shen-k'uei (Taiwan); **shenkui** (China) A Chinese folk label describing marked anxiety or panic symptoms with accompanying somatic complaints for which no physical cause can be demonstrated. Symptoms include dizziness, backache, fatigability, general weakness, insomnia, frequent dreams, and complaints of sexual dysfunction (such as premature ejaculation and impotence). Symptoms are attributed to excessive semen loss from frequent intercourse, masturbation, nocturnal emission, or passing of "white turbid urine" believed to contain semen. Excessive semen loss is feared because of the belief that it represents the loss of one's vital essence and can thereby be life threatening.

shin-byung A Korean folk label for a syndrome in which initial phases are characterized by anxiety and somatic complaints (general weakness, dizziness, fear, anorexia, insomnia, gastrointestinal problems), with subsequent dissociation and possession by ancestral spirits.

spell A trance state in which individuals "communicate" with deceased relatives or with spirits. At times this state is associated with brief periods of personality change. This culture-specific syndrome is seen among African Americans and European Americans from the southern United States. Spells are not considered to be medical events in the folk tradition but may be misconstrued as psychotic episodes in clinical settings.

susto ("fright," or "soul loss") A folk illness prevalent among some Latinos in the United States and among people in Mexico, Central America, and South America. Susto is also referred to as *espanto, pasmo, tripa ida, perdida del alma,* or *chibih.* Susto is an illness attributed to a frightening event that causes the soul to leave the body and results in unhappiness and sickness. Individuals with susto also experience significant strains in key social roles. Symptoms may appear any time from days to years after the fright is experienced. It is believed that in extreme cases, susto may result in death. Typical symptoms include appetite disturbances, inadequate or excessive sleep, troubled sleep or dreams, feeling of sadness, lack of motivation to do anything, and feelings of low self-worth or dirtiness. Somatic symptoms accompanying susto include muscle aches and pains, headache, stomachache, and diarrhea. Ritual healings are focused on calling the soul back to the body and cleansing the person to restore bodily and spiritual balance. Different experiences of susto may be related to Major Depressive Disorder, Posttraumatic Stress Disorder, and Somatoform Disorders. Similar etiological beliefs and symptom configurations are found in may parts of the world.

taijin kyofusho A culturally distinctive phobia in Japan, in some ways resembling Social Phobia in DSM-IV. This syndrome refers to an individual's intense fear that his or her body, its parts or its functions, displease, embarrass, or are offensive to other people in appearance, odor, facial expressions, or movements. This syndrome is included in the official Japanese diagnostic system for mental disorders.

zar A general term applied in Ethiopia, Somalia, Egypt, Sudan, Iran, and other North African and Middle Eastern societies to the experience of spirits possessing an individual. Persons possessed by a spirit may experience dissociative episodes that may include shouting, laughing, hitting the head against a wall, singing, or weeping. Individuals may show apathy and withdrawal, refusing to eat or carry out daily tasks, or may develop a long-term relationship with the possessing spirit. Such behavior is not considered pathological locally.

Appendix J

DSM-IV Contributors

Because DSM-IV is meant to be used by a diverse group of mental health professionals in a variety of settings, the Task Force on DSM-IV and the Work Groups solicited and encouraged the participation of a wide range of professionals to serve as advisers to the Task Force and individual Work Groups. Advisers included individuals from other health associations; clinical practitioners; researchers; forensic specialists; experts on gender, age, and cultural issues; and international experts. Advisory groups identified pertinent questions regarding each diagnosis; developed and critiqued literature reviews, text, and criteria; and participated in field-trial and data-reanalysis projects. The Task Force on DSM-IV and the Work Group members extend their appreciation and heartfelt thanks to the individuals and organizations who contributed so generously of their time and expertise.

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At the inception of the project, the Task Force on DSM-IV invited over 60 health associations to designate liaisons to the Task Force to ensure the openness of the revision process and to ensure that a variety of views would be represented. The associations listed below designated representatives who received regular communications from the Work Groups and the Task Force.

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American College of Physicians
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American Nurses' Association
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