DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FOURTH EDITION

TEXT REVISION

DSM-IV-TR™

AMERICAN PSYCHIATRIC ASSOCIATION

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DSM-IV-TR™

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To Melvin Sabshin,
a man for all seasons

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TASK FORCE ON DSM-IV

ALLEN FRANCES, M.D.
Chairperson

HAROLD ALAN PINCUS, M.D.
Vice-Chairperson

MICHAEL B. FIRST, M.D.
Editor, Text and Criteria

Nancy Coover Andreasen, M.D., Ph.D.
David H. Barlow, Ph.D.
Magda Campbell, M.D.
Dennis P. Cantwell, M.D.
Ellen Frank, Ph.D.
Judith H. Gold, M.D.
John Gunderson, M.D.
Robert E. Hales, M.D.
Kenneth S. Kendler, M.D.
David J. Kupfer, M.D.
Michael R. Liebowitz, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Peter E. Nathan, Ph.D.
Roger Peele, M.D.
Darrel A. Regier, M.D., M.P.H.
A. John Rush, M.D.
Chester W. Schmidt, M.D.
Marc Alan Schuckit, M.D.
David Shaffer, M.D.
Robert L. Spitzer, M.D.
Special Adviser
Gary J. Tucker, M.D.
B. Timothy Walsh, M.D.
Thomas A. Widiger, Ph.D.
Research Coordinator
Janet B. W. Williams, D.S.W.
John C. Urbaitis, M.D.
Assembly Liaison
James J. Hudziak, M.D.
Resident Fellow (1990–1993)
Junius Gonzales, M.D.
Resident Fellow (1988–1990)

Ruth Ross, M.A.
Science Editor
Nancy E. Vettorello, M.U.P.
Administrative Coordinator
Wendy Wakefield Davis, Ed.M.
Editorial Coordinator
Cindy D. Jones
Administrative Assistant
Nancy Sydnor-Greenberg, M.A.
Administrative Consultant
Myriam Kline, M.S.
Focused Field-Trial Coordinator
James W. Thompson, M.D., M.P.H.
Videotape Field-Trial Coordinator

The DSM-IV Text Revision Work Groups are listed on pp. xv–xvii.

Anxiety Disorders Work Group

Michael R. Liebowitz, M.D.
Chairperson
David H. Barlow, Ph.D.
Vice-Chairperson
James C. Ballenger, M.D.
Jonathan Davidson, M.D.
Edna Foa, Ph.D.
Abby Fyer, M.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders Work Group

Gary J. Tucker, M.D.
Chairperson
Michael Popkin, M.D.
Vice-Chairperson
Eric Douglas Caine, M.D.
Marshall Folstein, M.D.
Gary Lloyd Gottlieb, M.D.
Igor Grant, M.D.
Benjamin Liptzin, M.D.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Work Group

David Shaffer, M.D.
Co-Chairperson
Magda Campbell, M.D.
Co-Chairperson
Susan J. Bradley, M.D.
Dennis P. Cantwell, M.D.
Gabrielle A. Carlson, M.D.
Donald Jay Cohen, M.D.
Barry Garfinkel, M.D.
Rachel Klein, Ph.D.
Benjamin Lahey, Ph.D.
Rolf Loeber, Ph.D.
Jeffrey Newcorn, M.D.
Rhea Paul, Ph.D.
Judith H. L. Rapoport, M.D.
Sir Michael Rutter, M.D.
Fred Volkmar, M.D.
John S. Werry, M.D.

Eating Disorders Work Group

B. Timothy Walsh, M.D.
Chairperson
Paul Garfinkel, M.D.
Katherine A. Halmi, M.D.
James Mitchell, M.D.
G. Terence Wilson, Ph.D.

Mood Disorders Work Group

A. John Rush, M.D.
Chairperson
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Vice-Chairperson
Mark S. Bauer, M.D.
David Dunner, M.D.
Ellen Frank, Ph.D.
Donald F. Klein, M.D.

Multiaxial Issues Work Group

Janet B. W. Williams, D.S.W.
Chairperson
Howard H. Goldman, M.D., Ph.D.
Vice-Chairperson
Alan M. Gruenberg, M.D.
Juan Enrique Mezzich, M.D., Ph.D.
Roger Peele, M.D.
Stephen Setterberg, M.D.
Andrew Edward Skodol II, M.D.

Personality Disorders Work Group

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Chairperson
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Vice-Chairperson
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Bruce Pfohl, M.D.
Tracie Shea, Ph.D.
Larry Siever, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Work Group

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Jean Endicott, Ph.D.
Barbara Parry, M.D.
Sally Severino, M.D.
Nada Logan Stotland, M.D.
Ellen Frank, Ph.D.
Consultant

Psychiatric Systems Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Work Group

Robert E. Hales, M.D.
Chairperson
C. Robert Cloninger, M.D.
Vice-Chairperson
Jonathan F. Borus, M.D.
Jack Denning Burke, Jr., M.D., M.P.H.
Joe P. Fagan, M.D.
Steven A. King, M.D.
Ronald L. Martin, M.D.
Katharine Anne Phillips, M.D.
David Spiegel, M.D.
Alan Stoudemire, M.D.
James J. Strain, M.D.
Michael G. Wise, M.D.

Schizophrenia and Other Psychotic Disorders Work Group

Nancy Coover Andreasen, M.D., Ph.D.
Chairperson
John M. Kane, M.D.
Vice-Chairperson
Samuel Keith, M.D.
Kenneth S. Kendler, M.D.
Thomas McGlashan, M.D.

Sexual Disorders Work Group

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Chairperson
Raul Schiavi, M.D.
Leslie Schover, Ph.D.
Taylor Seagraves, M.D.
Thomas Nathan Wise, M.D.

Sleep Disorders Work Group

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Chairperson
Charles F. Reynolds III, M.D.
Vice-Chairperson
Daniel Buysse, M.D.
Roger Peele, M.D.
Quentin Regestein, M.D.
Michael Sateia, M.D.
Michael Thorpy, M.D.

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Marc Alan Schuckit, M.D.
Chairperson
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Peter E. Nathan, Ph.D.
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Leah Joan Dickstein, M.D. (1988–1991)
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Gerald L. Klerman, M.D. (deceased) (1988–1991)
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Jack D. Blaine, M.D.
Consultant (1987–1992)
Jerry M. Lewis, M.D.
Consultant (1988–1994)
Daniel J. Luchins, M.D.
Consultant (1987–1991)
Katharine Anne Phillips, M.D.
Consultant (1992–1994)
Cynthia Pearl Rose, M.D.
Consultant (1990–1994)
Louis Alan Moench, M.D.
Assembly Liaison (1991–1994)
Steven K. Dobscha, M.D.
Resident Fellow (1990–1992)
Mark Zimmerman, M.D.
Resident Fellow (1992–1994)

Joint Committee of the Board of Trustees and Assembly of District Branches on Issues Related to DSM-IV

Ronald A. Shellow, M.D.
Chairperson
Harvey Bluestone, M.D.
Leah Joan Dickstein, M.D.
Arthur John Farley, M.D.
Carol Ann Bernstein, M.D.

WORK GROUPS FOR THE DSM-IV TEXT REVISION

MICHAEL B. FIRST, M.D.
Co-Chairperson and Editor

HAROLD ALAN PINCUS, M.D.
Co-Chairperson

Laurie E. McQueen, M.S.S.W.
DSM Project Manager

Yoshie Satake, B.A.
DSM Program Coordinator

Anxiety Disorders Text Revision Work Group

Murray B. Stein, M.D.
Chairperson
Jonathan Abramowitz, Ph.D.
Gordon Asmundson, Ph.D.
Jean C. Beckham, Ph.D.
Timothy Brown, Ph.D., Psy.D.
Michelle Craske, Ph.D.
Edna Foa, Ph.D.
Thomas Mellman, M.D.
Ron Norton, Ph.D.
Franklin Schneier, M.D.
Richard Zinbarg, Ph.D.

Delirium, Dementia, and Amnestic and Other Cognitive Disorders and Mental Disorders Due to a General Medical Condition Text Revision Work Group

Eric Douglas Caine, M.D.
Jesse Fann, M.D., M.P.H.
Jeffrey M. Lyness, M.D.
Anton P. Porsteinsson, M.D.

Disorders Usually First Diagnosed During Infancy, Childhood, or Adolescence Text Revision Work Group

David Shaffer, M.D.
Chairperson
Donald J. Cohen, M.D.
Stephen Hinshaw, Ph.D.
Rachel G. Klein, Ph.D.
Ami Klin, Ph.D.
Daniel Pine, M.D.
Mark A. Riddle, M.D.
Fred R. Volkmar, M.D.
Charles Zeanah, M.D.

Eating Disorders Text Revision Work Group

Katharine L. Loeb, Ph.D.
B. Timothy Walsh, M.D.

Medication-Induced Movement Disorders Text Revision Work Group

Gerard Addonizio, M.D.
Lenard Adler, M.D.
Burton Angrist, M.D.
Daniel Casey, M.D.
Alan Gelenberg, M.D.
James Jefferson, M.D.
Dilip Jeste, M.D.
Peter Weiden, M.D.

Mood Disorders Text Revision Work Group

Mark S. Bauer, M.D.
Patricia Suppes, M.D., Ph.D.
Michael E. Thase, M.D.

Multiaxial Text Revision Work Group

Alan M. Gruenberg, M.D.

Personality Disorders Text Revision Work Group

Bruce Pfohl, M.D.
Thomas A. Widiger, Ph.D.

Premenstrual Dysphoric Disorder Text Revision Work Group

Sally Severino, M.D.

Psychiatric System Interface Disorders (Adjustment, Dissociative, Factitious, Impulse-Control, and Somatoform Disorders and Psychological Factors Affecting Medical Conditions) Text Revision Work Group

Mitchell Cohen, M.D.
Marc Feldman, M.D.
Eric Hollander, M.D.
Steven A. King, M.D.
James Levenson, M.D.
Ronald L. Martin, M.D. (deceased)
Jeffrey Newcorn, M.D.
Russell Noyes, Jr., M.D.
Katharine Anne Phillips. M.D.
Eyal Shemesh, M.D.
David Spiegel, M.D.
James J. Strain, M.D.
Sean H. Yutzy, M.D.

Schizophrenia and Other Psychotic Disorders Text Revision Work Group

Michael Flaum, M.D.
Co-Chairperson
Xavier Amador, Ph.D.
Co-Chairperson

Sexual and Gender Identity Disorders Text Revision Work Group

Chester W. Schmidt, M.D.
R. Taylor Segraves, M.D.
Thomas Nathan Wise, M.D.
Kenneth J. Zucker, Ph.D.

Sleep Disorders Text Revision Work Group

Daniel Buysse, M.D.
Peter Nowell, M.D.

Substance-Related Disorders Text Revision Work Group

Marc Alan Schuckit, M.D.

American Psychiatric Association
Committee on Psychiatric Diagnosis and Assessment

David J. Kupfer, M.D.
Chair

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Member

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Member

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Member

Barbara Kennedy, M.D., Ph.D.
Consultant

Janet B. W. Williams, D.S.W.
Consultant

Louis Alan Moench, M.D.
Assembly Liaison

Jack Barchas, M.D.
Corresponding Member

Herbert W. Harris, M.D., Ph.D.
Corresponding Member

Charles Kaelber, M.D.
Corresponding Member

Jorge A. Costa e Silva, M.D.
Corresponding Member

T. Bedirhan Ustun, M.D.
Corresponding Member

Yeshuschandra Dhaibar, M.D.
APA/Glaxo-Wellcome Fellow

Acknowledgments for DSM-IV

DSM-IV was a team effort. More than 1,000 people (and numerous professional organizations) have helped us in the preparation of this document. Members of the Task Force on DSM-IV and DSM-IV Staff are listed on p. xi, members of the DSM-IV Work Groups are listed on pp. xii–xiv, and a list of other participants is included in Appendix J.

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

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Allen Frances, M.D.
Chairperson, Task Force on DSM-IV

Harold Alan Pincus, M.D.
Vice-Chairperson, Task Force on DSM-IV

Michael B. First, M.D.
Editor, DSM-IV Text and Criteria

Thomas A. Widiger, Ph.D.
Research Coordinator

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Acknowledgments for DSM-IV Text Revision

The effort to revise the DSM-IV text was also a team effort. We are especially indebted to the tireless efforts of the DSM-IV Text Revision Work Groups (listed on pp. xv–xvii), who did the lion's share of the work in the preparation of this revision. We would also like to acknowledge the contribution of the various advisers to the Work Groups (see Appendix K, p. 929), who provided their perspective on whether the proposed changes were justified. Finally, we would like to thank the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment (listed on p. xvii), who provided helpful guidance and oversight during the process as well as approval of the final document. Special gratitude goes to committee members Katharine A. Phillips and Janet B. W. Williams, for their meticulously careful review of the text revision. Of course, none of this could have happened without the invaluable organizational and administrative assistance provided by the DSM-IV staff, Laurie McQueen and Yoshie Satake, and production assistance provided by Anne Barnes, Pam Harley, Greg Kuny, Claire Reinburg, and Ron McMillen at American Psychiatric Press.

Michael B. First, M.D.
Co-Chairperson and Editor

Harold Alan Pincus, M.D.
Co-Chairperson

Introduction

This is the fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, or DSM-IV. The utility and credibility of DSM-IV require that it focus on its clinical, research, and educational purposes and be supported by an extensive empirical foundation. Our highest priority has been to provide a helpful guide to clinical practice. We hoped to make DSM-IV practical and useful for clinicians by striving for brevity of criteria sets, clarity of language, and explicit statements of the constructs embodied in the diagnostic criteria. An additional goal was to facilitate research and improve communication among clinicians and researchers. We were also mindful of the use of DSM-IV for improving the collection of clinical information and as an educational tool for teaching psychopathology.

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

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

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

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

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

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

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

Historical Background

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

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

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

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

The American Psychiatric Association Committee on Nomenclature and Statistics developed a variant of the ICD-6 that was published in 1952 as the first edition of the *Diagnostic and Statistical Manual: Mental Disorders* (DSM-I). DSM-I contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical utility. The use of the term *reaction* throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors.

In part because of the lack of widespread acceptance of the mental disorder taxonomy contained in ICD-6 and ICD-7, WHO sponsored a comprehensive review of diagnostic issues that was conducted by the British psychiatrist Stengel. His report can be credited with having inspired many of the recent advances in diagnostic methodology—most especially the need for explicit definitions as a means of promoting reliable clinical diagnoses. However, the next round of diagnostic revision, which led to DSM-II and ICD-8, did not follow Stengel's recommendations to any great degree. DSM-II was similar to DSM-I but eliminated the term *reaction*.

As had been the case for DSM-I and DSM-II, the development of DSM-III was co-

ordinated with the development of the next (ninth) version of ICD, which was published in 1975 and implemented in 1978. Work began on DSM-III in 1974, with publication in 1980. DSM-III introduced a number of important methodological innovations, including explicit diagnostic criteria, a multiaxial system, and a descriptive approach that attempted to be neutral with respect to theories of etiology. This effort was facilitated by the extensive empirical work then under way on the construction and validation of explicit diagnostic criteria and the development of semistructured interviews. ICD-9 did not include diagnostic criteria or a multiaxial system largely because the primary function of this international system was to delineate categories to facilitate the collection of basic health statistics. In contrast, DSM-III was developed with the additional goal of providing a medical nomenclature for clinicians and researchers. Because of dissatisfaction across all of medicine with the lack of specificity in ICD-9, a decision was made to modify it for use in the United States, resulting in ICD-9-CM (for Clinical Modification).

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

The DSM-IV Revision Process

The third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) represented a major advance in the diagnosis of mental disorders and greatly facilitated empirical research. The development of DSM-IV has benefited from the substantial increase in the research on diagnosis that was generated in part by DSM-III and DSM-III-R. Most diagnoses now have an empirical literature or available data sets that are relevant to decisions regarding the revision of the diagnostic manual. The Task Force on DSM-IV and its Work Groups conducted a three-stage empirical process that included 1) comprehensive and systematic reviews of the published literature, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials.

Literature Reviews

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

Each literature review specified 1) the issues or aspects of the text and criteria under consideration and the significance of the issues with respect to DSM-IV; 2) the review method (including the sources for identifying relevant studies, the number of

studies considered, the criteria for inclusion and exclusion from the review, and the variables catalogued in each study); 3) the results of the review (including a descriptive summary of the studies with respect to methodology, design, and substantive correlates of the findings, the relevant findings, and the analyses conducted on these findings); and 4) the various options for resolving the issue, the advantages and disadvantages of each option, recommendations, and suggestions for additional research that would be needed to provide a more conclusive resolution.

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

Data Reanalyses

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

Field Trials

Twelve DSM-IV field trials were sponsored by the National Institute of Mental Health (NIMH) in collaboration with the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The field trials allowed the DSM-IV Work Groups to compare alternative options and to study the possible impact of suggested changes. Field trials compared DSM-III, DSM-III-R, ICD-10, and proposed DSM-IV criteria sets in 5–10 different sites per field trial, with approximately 100 subjects at each site. Diverse sites, with representative groups of subjects from a range of sociocultural and ethnic backgrounds, were selected to ensure generalizability of field-trial results and to test some of the most difficult ques-

tions in differential diagnosis. The 12 field trials included more than 70 sites and evaluated more than 6,000 subjects. The field trials collected information on the reliability and performance characteristics of each criteria set as a whole, as well as of the specific items within each criteria set. The field trials also helped to bridge the boundary between clinical research and clinical practice by determining how well suggestions for change that are derived from clinical research findings apply in clinical practice.

Criteria for Change

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

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

The *DSM-IV Sourcebook*

Documentation has been the essential foundation of the DSM-IV process. The *DSM-IV Sourcebook,* published in four volumes, is intended to provide a comprehensive and convenient reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force. The first three volumes of the *Sourcebook* contain condensed versions of the 150 DSM-IV literature reviews. The

fourth volume contains reports of the data reanalyses, reports of the field trials, and a final executive summary of the rationale for the decisions made by each Work Group. In addition, many papers were stimulated by the efforts toward empirical documentation in DSM-IV, and these have been published in peer-reviewed journals.

Relation to ICD-10

The tenth revision of the *International Statistical Classification of Diseases and Related Health Problems* (ICD-10), developed by WHO, was published in 1992. A clinical modification of ICD-10 (ICD-10-CM) is expected to be implemented in the United States in 2004. Those preparing ICD-10 and DSM-IV have worked closely to coordinate their efforts, resulting in much mutual influence. ICD-10 consists of an official coding system and other related clinical and research documents and instruments. The codes and terms provided in DSM-IV are fully compatible with both ICD-9-CM and ICD-10 (see Appendix H). The clinical and research drafts of ICD-10 were thoroughly reviewed by the DSM-IV Work Groups and suggested important topics for DSM-IV literature reviews and data reanalyses. Draft versions of the ICD-10 Diagnostic Criteria for Research were included as alternatives to be compared with DSM-III, DSM-III-R, and suggested DSM-IV criteria sets in the DSM-IV field trials. The many consultations between the developers of DSM-IV and ICD-10 (which were facilitated by NIMH, NIDA, and NIAAA) were enormously useful in increasing the congruence and reducing meaningless differences in wording between the two systems.

The DSM-IV Text Revision

One of the most important uses of DSM-IV has been as an educational tool. This is especially true of the descriptive text that accompanies the criteria sets for DSM-IV disorders. Given that the interval between DSM-IV and DSM-V is being extended relative to the intervals between earlier editions (from 7 years between DSM-III and DSM-III-R and between DSM-III-R and DSM-IV, to at least 12 years), the information in the text (which was prepared on the basis of literature dating up to 1992) runs the risk of becoming increasingly out-of-pace with the large volume of research published each year. In order to bridge the span between DSM-IV and DSM-V, a revision of the DSM-IV text was undertaken. The goals of this text revision were severalfold: 1) to correct any factual errors that were identified in the DSM-IV text; 2) to review the DSM-IV text to ensure that all of the information is still up-to-date; 3) to make changes to the DSM-IV text to reflect new information available since the DSM-IV literature reviews were completed in 1992; 4) to make improvements that will enhance the educational value of DSM-IV; and 5) to update those ICD-9-CM codes that were changed since the DSM-IV 1996 Coding Update. As with the original DSM-IV, all changes proposed for the text had to be supported by empirical data. Furthermore, all proposed changes were limited to the text sections (e.g., Associated Features and Disorders, Prevalence). No substantive changes in the criteria sets were considered, nor were any proposals entertained for new disorders, new subtypes, or changes in the status of the DSM-IV appendix categories.

The text revision process began in 1997 with the appointment of DSM-IV Text Revision Work Groups, corresponding to the original DSM-IV Work Group structure.

The chairs of the original DSM-IV Work Groups were consulted first regarding the composition of these Text Revision Work Groups. Each Text Revision Work Group was given primary responsibility for updating a section of the DSM-IV text. This entailed reviewing the text carefully to identify errors or omissions and then conducting a systematic, comprehensive literature review that focused on relevant material that has been published since 1992. Text Revision Work Group members then drafted proposed changes, which were accompanied by written justifications for the changes along with relevant references. During a series of conference calls, the proposed changes, justifications, and references were presented by a Text Revision Work Group member to other members of the Text Revision Work Group, who provided input regarding whether the changes were justified on the basis of the supporting documentation. Once drafts of the proposed changes were finalized by the Text Revision Work Groups, the changes were more widely disseminated to a group of section-specific advisers (consisting of the original DSM-IV Work Group members supplemented by additional consultants) for further comment and review. These advisers were also given the opportunity to suggest additional changes if they could provide sufficient convincing evidence justifying inclusion in the text. After consideration of the adviser comments, final drafts of proposed changes were produced and submitted for final review and approval by the American Psychiatric Association's Committee on Psychiatric Diagnosis and Assessment.

Most of the proposed literature-based changes were in the Associated Features and Disorders (which includes Associated Laboratory Findings); Specific Culture, Age, and Gender Features; Prevalence; Course; and Familial Pattern sections of the text. For a number of disorders, the Differential Diagnosis section also was expanded to provide more comprehensive differentials. Appendix D (see p. 829) provides an overview of the changes included in this text revision.

Definition of *Mental Disorder*

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

Moreover, although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of "mental disorder." The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations. All medical conditions are defined on various levels of abstraction—for example, structural pathology (e.g., ulcerative colitis), symptom presentation (e.g., migraine), deviance from a physiological norm (e.g., hypertension), and etiology (e.g., pneumococcal pneumonia). Mental disorders have also been defined by a variety of concepts (e.g., distress, dysfunction, dyscontrol, disadvantage, disability, inflexibility, irrationality, syndromal pattern, etiology, and statistical deviation). Each

is a useful indicator for a mental disorder, but none is equivalent to the concept, and different situations call for different definitions.

Despite these caveats, the definition of *mental disorder* that was included in DSM-III and DSM-III-R is presented here because it is as useful as any other available definition and has helped to guide decisions regarding which conditions on the boundary between normality and pathology should be included in DSM-IV. In DSM-IV, each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.

A common misconception is that a classification of mental disorders classifies people, when actually what are being classified are disorders that people have. For this reason, the text of DSM-IV (as did the text of DSM-III-R) avoids the use of such expressions as "a schizophrenic" or "an alcoholic" and instead uses the more accurate, but admittedly more cumbersome, "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

Issues in the Use of DSM-IV

Limitations of the Categorical Approach

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

In DSM-IV, there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. There is also no assumption that all individuals described as having the same mental disorder are alike in all important ways. The clinician using DSM-IV should therefore consider that individuals sharing a diagnosis are likely to be heterogeneous even in regard to the defining features of the diagnosis and that boundary cases will be difficult to diagnose in any but a probabilistic fashion. This outlook allows greater flexibility in the use of the system, encourages more specific attention to boundary cases, and emphasizes the need to capture additional

clinical information that goes beyond diagnosis. In recognition of the heterogeneity of clinical presentations, DSM-IV often includes polythetic criteria sets, in which the individual need only present with a subset of items from a longer list (e.g., the diagnosis of Borderline Personality Disorder requires only five out of nine items).

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

Use of Clinical Judgment

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

In addition to the need for clinical training and judgment, the method of data collection is also important. The valid application of the diagnostic criteria included in this manual necessitates an evaluation that directly accesses the information contained in the criteria sets (e.g., whether a syndrome has persisted for a minimum period of time). Assessments that rely solely on psychological testing not covering the criteria content (e.g., projective testing) cannot be validly used as the primary source of diagnostic information.

Use of DSM-IV in Forensic Settings

When the DSM-IV categories, criteria, and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be mis-

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

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

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

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

Ethnic and Cultural Considerations

Special efforts have been made in the preparation of DSM-IV to incorporate an awareness that the manual is used in culturally diverse populations in the United States and

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

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

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

The second type of cultural information provided pertains to "culture-bound syndromes" that have been described in just one, or a few, of the world's societies. DSM-IV provides two ways of increasing the recognition of culture-bound syndromes: 1) some (e.g., *amok, ataque de nervios*) are included as separate examples in Not Otherwise Specified categories; and 2) an appendix of culture-bound syndromes (Appendix I) has been introduced in DSM-IV that includes the name for the condition, the cultures in which it was first described, and a brief description of the psychopathology.

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

Use of DSM-IV in Treatment Planning

Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require consider-

able additional information about the person being evaluated beyond that required to make a DSM-IV diagnosis.

Distinction Between *Mental Disorder* and *General Medical Condition*

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

Organization of the Manual

The manual begins with instructions concerning the use of the manual (p. 1), followed by the DSM-IV-TR Classification (pp. 13–26), which provides a systematic listing of the official codes and categories. Next is a description of the DSM-IV Multiaxial System for assessment (pp. 27–37). This is followed by the diagnostic criteria for each of the DSM-IV disorders accompanied by descriptive text (pp. 39–743). Finally, DSM-IV includes 11 appendixes.

Cautionary Statement

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

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

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

Schizophrenia and Other Psychotic Disorders

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

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

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

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

The following disorders are included in this section:

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

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

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

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

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

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

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

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

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

Schizophrenia

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subtypes and Course Specifiers

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

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

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

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

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

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

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

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

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

Recording Procedures

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

Associated Features and Disorders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specific Culture, Age, and Gender Features

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

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

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

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

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

Prevalence

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

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

Course

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

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

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

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

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

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

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

Diagnostic criteria for Schizophrenia

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

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

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

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

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

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

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

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

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

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

Diagnostic criteria for Schizophrenia *(continued)*

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

Schizophrenia Subtypes

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

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

295.30 Paranoid Type

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

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

Diagnostic criteria for 295.30 Paranoid Type

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

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

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

295.10 Disorganized Type

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

Diagnostic criteria for 295.10 Disorganized Type

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

A. All of the following are prominent:

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

B. The criteria are not met for Catatonic Type.

295.20 Catatonic Type

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

Diagnostic criteria for 295.20 Catatonic Type

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

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

295.90 Undifferentiated Type

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

Diagnostic criteria for 295.90 Undifferentiated Type

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

295.60 Residual Type

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

Diagnostic criteria for 295.60 Residual Type

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

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

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

295.40 Schizophreniform Disorder

Diagnostic Features

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

Specifiers

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

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

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

Associated Features and Disorders

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

Specific Culture, Age, and Gender Features

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

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

Diagnostic criteria for 295.40 Schizophreniform Disorder

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

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

Specify if:

Without Good Prognostic Features

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

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

295.70 Schizoaffective Disorder

Diagnostic Features

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

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

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

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

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

Subtypes

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

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

Associated Features and Disorders

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

Specific Culture, Age, and Gender Features

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

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

Diagnostic criteria for 295.70 Schizoaffective Disorder

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

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

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

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

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

Specify type:

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

297.1 Delusional Disorder

Diagnostic Features

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

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

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

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

Subtypes

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

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

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

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

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

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

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

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

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

Associated Features and Disorders

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

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

Specific Culture and Gender Features

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

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

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

Diagnostic criteria for 297.1 Delusional Disorder

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

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

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

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

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

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

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

298.8 Brief Psychotic Disorder

Diagnostic Features

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

Specifiers

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

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

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

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

Associated Features and Disorders

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

Specific Culture Features

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

Prevalence

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

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

Course

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

Diagnostic criteria for 298.8 Brief Psychotic Disorder

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

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

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

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

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

Specify if:

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

297.3 Shared Psychotic Disorder (Folie à Deux)

Diagnostic Features

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

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

Associated Features and Disorders

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

Prevalence

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

Course

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

Differential Diagnosis

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

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

Diagnostic criteria for 297.3 Shared Psychotic Disorder

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

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

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

Psychotic Disorder Due to a General Medical Condition

Diagnostic Features

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

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

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

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

Subtypes

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

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

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

Recording Procedures

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

Associated General Medical Conditions

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

Prevalence

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

Course

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

Differential Diagnosis

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

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

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

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

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

A. Prominent hallucinations or delusions.

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

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

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

Code based on predominant symptom:

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

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

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

Substance-Induced Psychotic Disorder

Diagnostic Features

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

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

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

Subtypes and Specifiers

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

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

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

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

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

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

Recording Procedures

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

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

Specific Substances

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

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

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

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

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

Differential Diagnosis

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

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

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

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

Diagnostic criteria for Substance-Induced Psychotic Disorder

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

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

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

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

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

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

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

Code [Specific Substance]–Induced Psychotic Disorder:

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

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

With Onset During Intoxication: if criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

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

298.9 Psychotic Disorder Not Otherwise Specified

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

Examples include

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

Mood Disorders

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

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

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

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

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

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

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

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

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

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

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

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

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

The Mood Disorders section is organized as follows:

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

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

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

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

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

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

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

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

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

For Major Depressive Disorder:

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

For Bipolar I Disorder:

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

For Bipolar II Disorder, the diagnostic code is 296.89.

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

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

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

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

Mood Episodes

Major Depressive Episode

Episode Features

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

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

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

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

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

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

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

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

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

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

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

ilure to make expected

jor Depressive Episode
insomnia (i.e., waking
) or terminal insomnia
itial insomnia (i.e., dif-
uals present with over-
es at night or increased
treatment is for the dis-

o sit still, pacing, hand-
r objects) or retardation
ased pauses before an-
nt, or variety of content,
ardation must be severe
subjective feelings.
Criterion A6). A person
the smallest tasks seem
are accomplished may
washing and dressing in

jor Depressive Episode
r guilty preoccupations
individuals often mis-
ersonal defects and have
. For example, a realtor
ke sales even when the
ly unable to make sales.
ortions (e.g., an individ-
ible for world poverty).
national or interpersonal
and, unless delusional,

ntrate, or make decisions
n of memory difficulties.
pursuits are often unable
ration problems (e.g., a
ted but previously man-
y reflect poor concentra-
memory difficulties may
of a dementia ("pseudo-
ally treated, the memory
particularly elderly per-
tial presentation of an ir-

tion, or suicide attempts
ers would be better off if

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

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

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

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

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

Associated Features and Disorders

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

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

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

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

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

Specific Culture, Age, and Gender Features

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

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

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

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

Course

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

Differential Diagnosis

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

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

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

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

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

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

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

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

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

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

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

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

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

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

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

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

Manic Episode

Episode Features

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

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

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

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

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

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

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

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

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

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

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

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

Associated Features and Disorders

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

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

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

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

Specific Culture, Age, and Gender Features

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

Course

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

Differential Diagnosis

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

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

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

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

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

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

Criteria for Manic Episode

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

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

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

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

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

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

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

Mixed Episode

Episode Features

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

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

Associated Features and Disorders

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

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

Specific Culture, Age, and Gender Features

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

Course

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

Differential Diagnosis

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

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

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

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

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Criteria for Mixed Episode

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

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

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

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

Hypomanic Episode

Episode Features

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

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

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

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

Associated Features and Disorders

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

Specific Culture and Age Features

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

Course

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

Differential Diagnosis

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

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

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

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

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

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

Criteria for Hypomanic Episode

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

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

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

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

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

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

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

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

Depressive Disorders

Major Depressive Disorder

Diagnostic Features

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

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

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

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

Specifiers

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

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

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

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

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

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

Recording Procedures

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

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

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

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

Associated Features and Disorders

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

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

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

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

Specific Culture, Age, and Gender Features

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

Prevalence

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

Course

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

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

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

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

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

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

Familial Pattern

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

Differential Diagnosis

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

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

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

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

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

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

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

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

Diagnostic criteria for 296.2x Major Depressive Disorder, Single Episode

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

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

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

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

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

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

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

Diagnostic criteria for 296.3x Major Depressive Disorder, Recurrent

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

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

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

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

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

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

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

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

Specify:

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

300.4 Dysthymic Disorder

Diagnostic Features

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

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

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

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

Specifiers

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

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

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

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

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

Associated Features and Disorders

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

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

Specific Age and Gender Features

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

See the "Differential Diagnosis" section for Major Depressive Disorder (p. 373). The differential diagnosis between Dysthymic Disorder and **Major Depressive Disorder** is made particularly difficult by the facts that the two disorders share similar symptoms and that the differences between them in onset, duration, persistence, and severity are not easy to evaluate retrospectively. Usually Major Depressive Disorder consists of one or more discrete Major Depressive Episodes that can be distinguished from the person's usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years. When Dysthymic Disorder is of many years' duration, the mood disturbance may not be easily distinguished from the person's "usual" functioning. If the initial onset of chronic depressive symptoms is of sufficient severity and number to meet full criteria for a Major Depressive Episode, the diagnosis would be Major Depressive Disorder, Chronic (if the full criteria are still met), or Major Depressive Disorder, In Partial Remission (if the full criteria are no longer met). The diagnosis of Dysthymic Disorder can be made following Major Depressive Disorder only if the Dysthymic Disorder was established prior to the first Major Depressive Episode (i.e., no Major Depressive Episodes during the first 2 years of dysthymic symptoms), or if there has been a full remission of the Major Depressive Disorder (i.e., lasting at least 2 months) before the onset of the Dysthymic Disorder.

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

Dysthymic Disorder must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition, With Depressive Features, if the mood disturbance is judged to be the direct physiological consequence of a specific, usually chronic, general medical condition (e.g., multiple sclerosis) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Dysthymic Disorder) and the general medical condition is recorded on Axis III (e.g., diabetes mellitus). This would be the case, for example, if the depressive symptoms are considered to be the psychological consequence of having a chronic general medical condition or if there is no etiological relationship between the depressive symptoms and the general medical condition. A **Substance-Induced Mood Disorder** is distinguished from a Dysthymic Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405).

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

Diagnostic criteria for 300.4 Dysthymic Disorder

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

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

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

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

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

Diagnostic criteria for 300.4 Dysthymic Disorder *(continued)*

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

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

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

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

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

Specify if:

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

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

With Atypical Features (see p. 420)

311 Depressive Disorder Not Otherwise Specified

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

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

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

Bipolar Disorders

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

Bipolar I Disorder

Diagnostic Features

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

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

Specifiers

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

Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features (see p. 411)
With Catatonic Features (see p. 417)
With Postpartum Onset (see p. 422)

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

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

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

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

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

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

Recording Procedures

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

1. The first three digits are 296.
2. The fourth digit is 0 if there is a single Manic Episode. For recurrent episodes, the fourth digit indicates the nature of the current episode (or, if the Bipolar I Dis-

order is currently in partial or full remission, the nature of the most recent episode) as follows: 4 if the current or most recent episode is a Hypomanic Episode or a Manic Episode, 5 if it is a Major Depressive Episode, 6 if it is a Mixed Episode, and 7 if the current or most recent episode is Unspecified.

3. The fifth digit (except for Bipolar I Disorder, Most Recent Episode Hypomanic, and Bipolar I Disorder, Most Recent Episode Unspecified) indicates the severity of the current episode if full criteria are met for a Manic, Mixed, or Major Depressive Episode as follows: 1 for Mild severity, 2 for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features. If full criteria are not met for a Manic, Mixed, or Major Depressive Episode, the fifth digit indicates the current clinical status of the Bipolar I Disorder as follows: 5 for In Partial Remission, 6 for In Full Remission. If current severity or clinical status is unspecified, the fifth digit is 0. Other specifiers for Bipolar I Disorder cannot be coded. For Bipolar I Disorder, Most Recent Episode Hypomanic, the fifth digit is always 0. For Bipolar Disorder, Most Recent Episode Unspecified, there is no fifth digit.

In recording the name of a diagnosis, terms should be listed in the following order: Bipolar I Disorder, specifiers coded in the fourth digit (e.g., Most Recent Episode Manic), specifiers coded in the fifth digit (e.g., Mild, Severe With Psychotic Features, In Partial Remission), as many specifiers (without codes) as apply to the current or most recent episode (e.g., With Melancholic Features, With Postpartum Onset), and as many specifiers (without codes) as apply to the course of episodes (e.g., With Rapid Cycling); for example, 296.54 Bipolar I Disorder, Most Recent Episode Depressed, Severe With Psychotic Features, With Melancholic Features, With Rapid Cycling.

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

Associated Features and Disorders

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

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

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

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

Specific Culture, Age, and Gender Features

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

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

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

Prevalence

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

Course

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

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

Familial Pattern

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

Differential Diagnosis

Major Depressive, Manic, Mixed, and Hypomanic Episodes in Bipolar I Disorder must be distinguished from episodes of a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination.

A **Substance-Induced Mood Disorder** is distinguished from Major Depressive, Manic, or Mixed Episodes that occur in Bipolar I Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Manic,

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

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

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

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

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

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

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

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

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

Specify if:

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

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

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

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

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

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

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

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

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

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

Specify:

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

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

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

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

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

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

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

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

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

Specify:

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

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

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

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

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

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

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

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

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

Specify:

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

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

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

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

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

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

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

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

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

Specify:

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

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

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

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

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

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

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

Specify:

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

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

Diagnostic Features

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

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

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

Specifiers

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

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

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

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

If the full criteria are not currently met for a Hypomanic or Major Depressive Episode, the following specifiers may be used to describe the current clinical status of the Bipolar II Disorder and to describe features of the most recent Major Depressive Episode (only if it is the most recent type of mood episode):

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

The following specifiers may be used to indicate the pattern or frequency of episodes:

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

Recording Procedures

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

Associated Features and Disorders

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

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

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

Specific Gender Features

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

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

Prevalence

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

Course

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

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

Familial Pattern

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

Differential Diagnosis

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

The diagnosis is Mood Disorder Due to a General Medical Condition for episodes that are judged to be the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination.

A **Substance-Induced Mood Disorder** is distinguished from Hypomanic or Major Depressive Episodes that occur in Bipolar II Disorder by the fact that a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is judged to be etiologically related to the mood disturbance (see p. 405). Symptoms like those seen in a Hypomanic Episode may be part of an intoxication with or withdrawal from a drug of abuse and should be diagnosed as a Substance-Induced Mood Disorder (e.g., a major depressive–like episode occurring only in the context of withdrawal from cocaine would be diagnosed as Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal). Symptoms like those seen in a Hypomanic Episode may also be precipitated by antidepressant treatment such as medication, electroconvulsive therapy, or light therapy. Such episodes may be diagnosed as a Substance-Induced Mood Disorder (e.g., Amitriptyline-Induced Mood Disorder, With Manic Features; Electroconvulsive Therapy–Induced Mood Disorder, With Manic Features) and would not count toward a diagnosis of Bipolar II Disorder. However, when the substance use or medication is judged not to fully account for the episode (e.g., the episode continues for a considerable period autonomously after the substance is discontinued), the episode would count toward a diagnosis of Bipolar II Disorder.

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

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

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

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Diagnostic criteria for 296.89 Bipolar II Disorder

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

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

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

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

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

Specify current or most recent episode:

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

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

Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic Features (see p. 411) **Note:** Fifth-digit codes specified on p. 413 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Hypomanic or Major Depressive Episode, *specify* the clinical status of the Bipolar II Disorder and/or features of the most recent Major Depressive Episode (only if it is the most recent type of mood episode):

In Partial Remission, In Full Remission (see p. 411) **Note:** Fifth-digit codes specified on p. 413 cannot be used here because the code for Bipolar II Disorder already uses the fifth digit.
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

Specify:

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

301.13 Cyclothymic Disorder

Diagnostic Features

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

Associated Features and Disorders

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

Specific Age and Gender Features

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

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

Prevalence

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

Course

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

Familial Pattern

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

Differential Diagnosis

Cyclothymic Disorder must be distinguished from a **Mood Disorder Due to a General Medical Condition.** The diagnosis is Mood Disorder Due to a General Medical Condition, With Mixed Features, when the mood disturbance is judged to be the direct physiological consequence of a specific, usually chronic general medical condition (e.g., hyperthyroidism) (see p. 401). This determination is based on the history, laboratory findings, or physical examination. If it is judged that the depressive symptoms are not the direct physiological consequence of the general medical condition, then the primary Mood Disorder is recorded on Axis I (e.g., Cyclothymic Disorder) and the general medical condition is recorded on Axis III. This would be the case, for example, if the mood symptoms are considered to be the psychological consequence of having a chronic general medical condition or if there is no etiological relationship between the mood symptoms and the general medical condition.

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

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

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

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

Diagnostic criteria for 301.13 Cyclothymic Disorder

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

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

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

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

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

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

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

296.80 Bipolar Disorder Not Otherwise Specified

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

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

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

Other Mood Disorders

293.83 Mood Disorder Due to a General Medical Condition

Diagnostic Features

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

In determining whether the mood disturbance is due to a general medical condition, the clinician must first establish the presence of a general medical condition. Further, the clinician must establish that the mood disturbance is etiologically related to the general medical condition through a physiological mechanism. A careful and comprehensive assessment of multiple factors is necessary to make this judgment. Although there are no infallible guidelines for determining whether the relationship between the mood disturbance and the general medical condition is etiological, several considerations provide some guidance in this area. One consideration is the presence of a temporal association between the onset, exacerbation, or remission of the general medical condition and that of the mood disturbance. A second consideration is the presence of features that are atypical of primary Mood Disorders (e.g., atypical age at

onset or course or absence of family history). Evidence from the literature that suggests that there can be a direct association between the general medical condition in question and the development of mood symptoms can provide a useful context in the assessment of a particular situation. In addition, the clinician must also judge that the disturbance is not better accounted for by a primary Mood Disorder, a Substance-Induced Mood Disorder, or other primary mental disorders (e.g., Adjustment Disorder). This determination is explained in greater detail in the "Mental Disorders Due to a General Medical Condition" section (p. 181).

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

Subtypes

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

With Depressive Features. This subtype is used if the predominant mood is depressed, but the full criteria for a Major Depressive Episode are not met.
With Major Depressive–Like Episode. This subtype is used if the full criteria (except Criterion D) for a Major Depressive Episode (see p. 356) are met.
With Manic Features. This subtype is used if the predominant mood is elevated, euphoric, or irritable.
With Mixed Features. This subtype is used if the symptoms of both mania and depression are present but neither predominates.

Recording Procedures

In recording the diagnosis of Mood Disorder Due to a General Medical Condition, the clinician should note both the specific phenomenology of the disturbance, including the appropriate subtype, and the identified general medical condition judged to be causing the disturbance on Axis I (e.g., 293.83 Mood Disorder Due to Thyrotoxicosis, With Manic Features). The ICD-9-CM code for the general medical condition should also be noted on Axis III (e.g., 242.9 thyrotoxicosis). (See Appendix G for a list of selected ICD-9-CM diagnostic codes for general medical conditions.)

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

Associated General Medical Conditions

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

Prevalence

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

Differential Diagnosis

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

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

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

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

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

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:
   (1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities
   (2) elevated, expansive, or irritable mood

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

C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Depressed Mood in response to the stress of having a general medical condition).

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

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

Specify type:

With Depressive Features: if the predominant mood is depressed but the full criteria are not met for a Major Depressive Episode
With Major Depressive–Like Episode: if the full criteria are met (except Criterion D) for a Major Depressive Episode (see p. 356)
With Manic Features: if the predominant mood is elevated, euphoric, or irritable
With Mixed Features: if the symptoms of both mania and depression are present but neither predominates

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

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

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

Substance-Induced Mood Disorder

Diagnostic Features

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

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

ample, the onset of a Manic Episode after age 45 years may suggest a substance-induced etiology. In contrast, factors that suggest that the mood symptoms are better accounted for by a primary Mood Disorder include persistence of mood symptoms for a substantial period of time (i.e., a month or more) after the end of Substance Intoxication or acute Substance Withdrawal; the development of mood symptoms that are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or a history of prior recurrent primary episodes of Mood Disorder.

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

Subtypes and Specifiers

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

With Depressive Features. This subtype is used if the predominant mood is depressed.

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

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

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

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

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

Recording Procedures

The name of the Substance-Induced Mood Disorder begins with the specific substance or somatic treatment (e.g., cocaine, amitriptyline, electroconvulsive therapy) that is presumed to be causing the mood symptoms. The diagnostic code is selected from the listing of classes of substances provided in the criteria set. For substances that do not fit into any of the classes (e.g., amitriptyline) and for other somatic treatments (e.g., electroconvulsive therapy), the code for "Other Substance" should be used. In addition, for medications prescribed at therapeutic doses, the specific medication can be indicated by listing the appropriate E-code (see Appendix G). The name of the disorder (e.g., Cocaine-Induced Mood Disorder) is followed by the subtype indicating the predominant symptom presentation and the specifier indicating the context in which the symptoms developed (e.g., 292.84 Cocaine-Induced Mood Disorder, With Depressive Features, With Onset During Withdrawal). When more than one substance is judged to play a significant role in the development of mood symptoms, each should be listed separately (e.g., 292.84 Cocaine-Induced Mood Disorder, With Manic Features, With Onset During Withdrawal; 292.84 Light Therapy–Induced Mood Disorder, With Manic Features). If a substance is judged to be the etiological factor but the specific substance or class of substances is unknown, the category 292.84 Unknown Substance–Induced Mood Disorder may be used.

Specific Substances

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

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

Differential Diagnosis

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

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

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

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

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

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

Diagnostic criteria for Substance-Induced Mood Disorder

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

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

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

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

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

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

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

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

Code [Specific Substance]–Induced Mood Disorder:

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

Specify type:

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

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

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

296.90 Mood Disorder Not Otherwise Specified

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

Specifiers Describing Current or Most Recent Episode

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

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Table 1. Episode specifiers that apply to Mood Disorders

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

Severity/Psychotic/Remission Specifiers for Major Depressive Episode

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

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

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

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

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

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

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

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

.x1—Mild: Few, if any, symptoms in excess of those required to make the diagnosis and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.

.x2—Moderate: Symptoms or functional impairment between "mild" and "severe."

.x3—Severe Without Psychotic Features: Several symptoms in excess of those required to make the diagnosis, **and** symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

.x4—Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

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

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

.x6—In Full Remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

.x0—Unspecified.

Severity/Psychotic/Remission Specifiers for Manic Episode

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

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

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

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

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

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

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

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

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

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

Severity/Psychotic/Remission Specifiers for Mixed Episode

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

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

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

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

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

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

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

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

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

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

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

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

Chronic Specifier for a Major Depressive Episode

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

Criteria for Chronic Specifier

Specify if:

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

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

Catatonic Features Specifier

The specifier With Catatonic Features can be applied to the current Major Depressive, Manic, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder. If full criteria are no longer met for a mood episode, the specifier applies to the most recent mood episode. The specifier With Catatonic Features is appropriate when the clinical picture is characterized by marked psychomotor disturbance that

may involve motoric immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia, or echopraxia. Motoric immobility may be manifested by catalepsy (waxy flexibility) or stupor. The excessive motor activity is apparently purposeless and is not influenced by external stimuli. There may be extreme negativism that is manifested by the maintenance of a rigid posture against attempts to be moved or resistance to all instructions. Peculiarities of voluntary movement are manifested by the assumption of inappropriate or bizarre postures or by prominent grimacing. Echolalia (the pathological, parrotlike, and apparently senseless repetition of a word or phrase just spoken by another person) and echopraxia (the repetitive imitation of the movements of another person) are often present. Additional features may include stereotypies, mannerisms, and automatic obedience or mimicry. During severe catatonic stupor or excitement, the person may need careful supervision to avoid self-harm or harm to others. Potential consequences include malnutrition, exhaustion, hyperpyrexia, or self-inflicted injury.

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

Criteria for Catatonic Features Specifier

Specify if:

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

The clinical picture is dominated by at least two of the following:

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

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Melancholic Features Specifier

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

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

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

Criteria for Melancholic Features Specifier

Specify if:

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

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

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

B. Three (or more) of the following:

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

Atypical Features Specifier

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

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

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

Criteria for Atypical Features Specifier

Specify if:

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

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

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

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

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

Postpartum Onset Specifier

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

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

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

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

Criteria for Postpartum Onset Specifier

Specify if:

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

Onset of episode within 4 weeks postpartum

Specifiers Describing Course of Recurrent Episodes

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

Table 2. Course specifiers that apply to Mood Disorders

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

Longitudinal Course Specifiers (With and Without Full Interepisode Recovery)

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

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

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

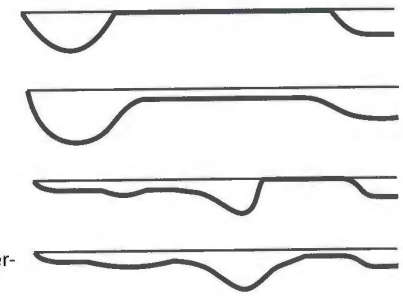
In general, individuals with a history of Without Full Interepisode Recovery have a persistence of that pattern between subsequent episodes. They also appear more likely to have more Major Depressive Episodes than those with full interepisode recovery. Dysthymic Disorder prior to the first episode of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

A. Recurrent, with full interepisode recovery, with no Dysthymic Disorder

B. Recurrent, without full interepisode recovery, with no Dysthymic disorder

C. Recurrent, with full interepisode recovery, superimposed on Dysthymic Disorder (also code 300.4)

D. Recurrent, without full interepisode recovery, superimposed on Dysthymic Disorder (also code 300.4)



Criteria for Longitudinal Course Specifiers

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

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

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

Seasonal Pattern Specifier

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

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

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

Criteria for Seasonal Pattern Specifier

Specify if:

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

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

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

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

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

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

Rapid-Cycling Specifier

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

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

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

Criteria for Rapid-Cycling Specifier

Specify if:

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

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

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