Diagnostic and Statistical Manual of Mental Disorders

(Third Edition)

DSM-III

American Psychiatric Association

DSM-III

First Printing, February 1980
Second Printing, May 1980

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Library of Congress Catalogue Number 79-055868

ACKNOWLEDGMENTS

This manual was prepared with the help of many people. Special thanks are given to the members of the Task Force on Nomenclature and Statistics, the various Advisory Committees and Other Consultants, and the members of the Assembly Liaison Task Force on DSM-III and the Board of Trustees Ad Hoc Committee on DSM-III. In addition, the work of the Field Trial participants, who are listed in Appendix F, is gratefully appreciated.

The following members of the American Psychiatric Association provided valuable help in arriving at creative solutions to difficult problems at various stages in the development of DSM-III: Drs. Alan A. Stone, President, and Chair, Board of Trustees; Donald G. Langsley, President-elect, and Chair, Reference Committee; Lester Grinspoon, Chair, Council on Research and Development; Edward J. Sachar, DSM-III liaison from Council on Research and Development; Melvin Sabshin, Medical Director; and Henry H. Work, Deputy Medical Director and DSM-III staff liaison.

Janet B. W. Williams, M.S.W., was invaluable in coordinating the Field Trials, in working with members of the Advisory Committees preparing sections of DSM-III and in integrating the extensive critiques of draft versions in the preparation of the final manual. Harriet Ayers's skill in keeping track of a voluminous correspondence and in typing revision after revision is deeply appreciated.

A final word of thanks must be given to the many other participants in this effort who have not received formal recognition, but who provided critiques and suggestions that were helpful in the preparation of DSM-III.

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Introduction

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Introduction

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This is the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, better known simply as DSM-III. The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many.

First of all, over the last decade there has been growing recognition of the importance of diagnosis for both clinical practice and research. Clinicians and research investigators must have a common language with which to communicate about the disorders for which they have professional responsibility. Planning a treatment program must begin with an accurate diagnostic assessment. The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined.

Secondly, from its very beginning, drafts of DSM-III have been widely circulated for critical review and use by clinicians and investigators. This made them aware of the many fundamental ways in which DSM-III differs from its predecessor, DSM-II, and from its international contemporary, the mental disorders chapter of the ninth revision of the *International Classification of Diseases* (ICD-9). For example, DSM-III includes such new features as diagnostic criteria, a multiaxial approach to evaluation, much-expanded descriptions of the disorders and many additional categories (some with newly-coined names); and it does not include several time-honored categories.

Finally, interest in the development of this manual is due to awareness that DSM-III reflects an increased commitment in our field to reliance on data as the basis for understanding mental disorders.

BACKGROUND*

The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term "reaction" throughout the classification reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In the development of the second edition (DSM-II), a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases*, for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and

* Some readers may wish, for now, to skip *Background* and *The Process of Development of DSM-III* and plunge directly into *Basic Concepts* on p.5.

ICD-8 went into effect in 1968. The DSM-II classification did not use the term "reaction" and used diagnostic terms that by and large did not imply a particular theoretical framework for understanding the nonorganic mental disorders.

In 1974 the American Psychiatric Association, through its Council on Research and Development, appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January 1979. By the time this new Task Force was constituted, the mental disorders section of ICD-9, which included its own glossary, was nearly completed. Although representatives of the American Psychiatric Association had worked closely with the World Health Organization in the development of ICD-9, there was some concern that the ICD-9 classification and glossary would not be suitable for use in the United States. Most importantly, many specific areas of the classification did not seem sufficiently detailed for clinical and research use. For example, the ICD-9 classification contains only one category for "frigidity and impotence"—despite the substantial work in the area of psychosexual dysfunctions that has identified several specific types with different clinical pictures and treatment implications. In addition, the glossary of ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodological developments as specified diagnostic criteria and the multiaxial approach to evaluation.

For these reasons the Task Force was directed to prepare a new classification and glossary that would, as much as possible, reflect the most current state of knowledge regarding mental disorders while maintaining compatibility with ICD-9. Like its predecessors, DSM-I and DSM-II, DSM-III had to be, first of all, clinically useful, while also providing a basis for research and administrative use.

The Task Force. Task Force members, and consultants from the fields of psychology and epidemiology, were selected because of their special interest in various aspects of diagnosis. Most had made significant contributions to the literature on diagnosis. As the work progressed, additional members were added to ensure representation of different perspectives and areas of expertise.

From the beginning, the Task Force functioned as a steering committee to oversee the ongoing work. All of its members shared a commitment to the attainment in DSM-III of the following goals:

—clinical usefulness for making treatment and management decisions in varied clinical settings;
—reliability of the diagnostic categories;
—acceptability to clinicians and researchers of varying theoretical orientations;
—usefulness for educating health professionals;
—maintaining compatibility with ICD-9, except when departures are unavoidable;
—avoiding the introduction of new terminology and concepts that break with tradition, except when clearly needed;
—reaching consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoiding the use of terms that have outlived their usefulness;
—consistency with data from research studies bearing on the validity of diagnostic categories;

—suitability for describing subjects in research studies;
—being responsive during the development of DSM-III to critiques by clinicians and researchers.

The major job of the Task Force has been to determine the most effective strategies for ensuring that the final document attained each goal to as great an extent as possible without compromising the other goals. Thus, the Task Force evaluated all proposals for changes in DSM-III that might affect the attainment of these goals. These proposals came from members of the Task Force, advisory committees, liaison committees with professional organizations, and participants in the DSM-III Field Trials. Finally, the Task Force reviewed drafts of the text and diagnostic criteria.

In attempting to resolve various diagnostic issues, the Task Force relied, as much as possible, on research evidence relevant to various kinds of diagnostic validity. For example, when discussing a problematic diagnostic category, the Task Force considered how the disorder, if defined as proposed, provided information relevant to treatment planning, course, and familial pattern. It should come as no surprise to the reader that even when data were available from relevant research studies, Task Force members often differed in their interpretations of the findings.

Advisory Committees and Other Consultants. Successive drafts of DSM-III were prepared by fourteen advisory committees composed of individuals with special expertise in each substantive area. In addition, a group of consultants provided advice and information on a variety of special areas.

Council on Research and Development. This component of the American Psychiatric Association appointed the Task Force and regularly reviewed progress being made in the development of DSM-III. In addition, in the fall of 1978 the Council held an all-day meeting at which some APA members voiced concerns about certain aspects of DSM-III. After reviewing these concerns, the Council approved the Task Force's approach to solutions of the problems that had been raised.

Assembly Liaison Committee. In early 1976, the APA Assembly, composed of representatives from all of the APA's district branches, appointed a Liaison Committee to review the development of DSM-III and to report regularly to the Assembly. This committee received correspondence on major issues, reviewed successive drafts of DSM-III, and met a number of times with the chairperson of the Task Force. On several occasions the Assembly Liaison Committee arranged for the chairperson of the Task Force to discuss a particular controversial issue with the entire Assembly. The Assembly Liaison Committee was invaluable in articulating the concerns of the membership of the APA, which is composed largely of clinicians whose primary professional activity is patient care.

Other Components of the APA. The chairperson of the Task Force reported on several occasions to the Reference Committee and the Board of Trustees on specific issues of concern. In addition, in April 1979, a meeting was held with an

Ad Hoc Committee on DSM-III of the Board of Trustees to review specific concerns about DSM-III that had been expressed by members of the APA. Other components of the APA, such as the Committee on Confidentiality and the Committee on Women, also reviewed DSM-III from their own perspectives as it was being developed.

Liaison with Other Professional Organizations. The following groups that were particularly interested in the development of DSM-III established liaison committees with the Task Force: the Academy of Psychiatry and the Law, the American Academy of Child Psychiatry, the American Academy of Psychoanalysis, the American Association of Chairmen of Departments of Psychiatry, the American College Health Association, the American Orthopsychiatric Association, the American Psychoanalytic Association, and the American Psychological Association. These committees received drafts of DSM-III and were invited to make comments and suggestions and to express their concerns. In most instances, differences in points of view between a liaison committee and the Task Force were resolved to the satisfaction of all concerned. When this was not possible and differences were left unresolved, the issues were at least clarified.

THE PROCESS OF DEVELOPMENT OF DSM-III

In May 1975, at a special session of the Annual Meeting of the APA, an initial draft of the DSM-III classification was presented. At each subsequent Annual Meeting a special session was held on some aspect of DSM-III. In addition, a special conference was held in St. Louis, Missouri, in June 1976, to examine "DSM-III in Midstream." This conference, co-sponsored by the Missouri Institute of Psychiatry and the American Psychiatric Association, was attended by approximately 100 professionals with expertise or special interests in various aspects of DSM-III, most of whom had previously had no direct involvement in the development of DSM-III. As a result of discussions at this conference, additional diagnostic categories were added, some were deleted, and a decision was made to proceed with the development of the multiaxial system.

The DSM-III classification and the rationale for the strategies used in its development have been presented throughout the past four years at local, national, and international professional meetings. In addition, the 4/15/77 draft and successive drafts of DSM-III have been available to the profession for critical review. Throughout this period there has been continual consideration of various solutions to difficult diagnostic problems, often based on summaries of actual cases submitted to the Task Force from all quarters. Whenever possible, attempts have been made to seek the advice of experts in each specific area under consideration.

Field Trials. In the past, new classifications of mental disorders have not been extensively subjected to clinical trials before official adoption. The Task Force believed that field trials using drafts of DSM-III should be conducted during the development process to identify problem areas in the classification and to try out solutions to these problems. In addition, because of the many proposed changes in the classification, it was important to demonstrate its clini-

cal acceptability and usefulness in a variety of settings by clinicians of varying theoretical orientations.

For these reasons, a series of field trials was conducted, beginning in 1977 and culminating in a two year NIMH-sponsored field trial from September 1977 to September 1979. In all, 12,667 patients were evaluated by approximately 550 clinicians, 474 of whom were in 212 different facilities, using successive drafts of DSM-III. Critiques of all portions of DSM-III by the field trial participants resulted in numerous changes, as did reviews of case summaries submitted by those participants. Frequently, participants completed questionnaires regarding specific diagnostic issues and their attitudes toward DSM-III and its innovative features. The results indicated that the great majority of participants, regardless of theoretical orientations, had a favorable response to DSM-III.

Perhaps the most important part of the study was the evaluation of diagnostic reliability by having pairs of clinicians make independent diagnostic judgments of several hundred patients. The results, which are presented in an appendix, generally indicate far greater reliability than had previously been obtained with DSM-II.

ICD-9-CM. Because of dissatisfaction with ICD-9 expressed by organizations representing subspecialties of medicine (not including the American Psychiatric Association), a decision was made to modify the ICD-9 for use in the United States by expanding the four-digit ICD-9 codes to five-digit ICD-9-CM (for clinical modification) codes whenever greater specificity was required. This modification was prepared for the United States National Center for Health Statistics by the Council on Clinical Classifications. The American Psychiatric Association, in December 1976, was invited to submit recommendations for alternate names and additional categories based on subdivisions of already existing ICD-9 categories. This made it possible for the developing DSM-III classification and its diagnostic terms to be included in the ICD-9-CM classification, which in January 1979 became the official system in this country for recording all "diseases, injuries, impairments, symptoms, and causes of death." The ICD-9-CM codes and diagnostic terms for mental disorders are included in Appendix D.

Many ICD-9-CM codes and terms are not included in the DSM-III classification. However, these are generally acceptable to third party payers and most record-keeping systems.

Final Approval. In May 1979, at the Annual Meeting of the APA in Chicago, the Assembly and the Council on Research and Development formally approved the final draft of DSM-III. In June, it was approved by the Reference Committee and the Board of Trustees.

BASIC CONCEPTS

Mental Disorder. Although this manual provides a classification of mental disorders, there is no satisfactory definition that specifies precise boundaries for the concept "mental disorder" (also true for such concepts as physical disorder and

mental and physical health). Nevertheless, it is useful to present concepts that have influenced the decision to include certain conditions in DSM-III as mental disorders and to exclude others.

In DSM-III 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 typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)

In DSM-III there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder. For example, there has been a continuing controversy as to whether or not severe depressive disorder and mild depressive disorder differ from each other qualitatively (discontinuity between diagnostic entities) or quantitatively (a difference on a severity continuum). The inclusion of Major Depression With and Without Melancholia as separate categories in DSM-III is justified by the clinical usefulness of the distinction. This does not imply a resolution of the controversy as to whether or not these conditions are in fact quantitatively or qualitatively different.

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

Another misconception is that all individuals described as having the same mental disorder are alike in all important ways. Although all the individuals described as having the same mental disorder show at least the defining features of the disorder, they may well differ in other important ways that may affect clinical management and outcome.

Conditions Not Attributable to a Mental Disorder. In DSM-III it is recognized that a behavioral or psychological problem may appropriately be a focus of professional attention or treatment even though it is not attributable to a mental disorder. A limited listing of codes, taken from the V codes section of ICD-9-CM, is provided for noting such problems.

Descriptive Approach. For some of the mental disorders, the etiology or pathophysiological processes are known. For example, in the Organic Mental Disorders, organic factors necessary for the development of the disorders have been identified or are presumed. Another example is Adjustment Disorder, in which the disturbance is a reaction to psychosocial stress.

For most of the DSM-III disorders, however, the etiology is unknown. A variety of theories have been advanced, buttressed by evidence—not always

convincing—to explain how these disorders come about. The approach taken in DSM-III is atheoretical with regard to etiology or pathophysiological process except for those disorders for which this is well established and therefore included in the definition of the disorder. Undoubtedly, with time, some of the disorders of unknown etiology will be found to have specific biological etiologies, others to have specific psychological causes, and still others to result mainly from a particular interplay of psychological, social and biological factors.

The major justification for the generally atheoretical approach taken in DSM-III with regard to etiology is that the inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations, since it would not be possible to present all reasonable etiological theories for each disorder. For example, Phobic Disorders are believed by many to represent a displacement of anxiety resulting from the breakdown of defensive operations for keeping internal conflict out of consciousness. Other investigators explain phobias on the basis of learned avoidance responses to conditioned anxiety. Still others believe that certain phobias result from a dysregulation of basic biological systems mediating separation anxiety. In any case, as the field trials have demonstrated, clinicians can agree on the identification of mental disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about.

Because DSM-III is generally atheoretical with regard to etiology, it attempts to describe comprehensively what the manifestations of the mental disorders are, and only rarely attempts to account for *how* the disturbances come about, unless the mechanism is included in the definition of the disorder. This approach can be said to be "descriptive" in that the definitions of the disorders generally consist of descriptions of the clinical features of the disorders. These features are described at the lowest order of inference necessary to describe the characteristic features of the disorder. Frequently the order of inference is relatively low, and the characteristic features consist of easily identifiable behavioral signs or symptoms, such as disorientation, mood disturbance, or psychomotor agitation. For some disorders, however, particularly the Personality Disorders, a much higher order of inference is necessary. For example, one of the criteria for Borderline Personality Disorder is "identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values and loyalties."

This descriptive approach is also used in the division of the mental disorders into diagnostic classes. All of the disorders without known etiology or pathophysiological process are grouped together on the basis of shared clinical features.

The subdivision of each diagnostic class into specific disorders, with even further subdivision in some cases, reflects the best judgment of the Task Force and its Advisory Committees that such subdivision will be useful. In this regard we have been guided by the judgments of those clinicians who will be making most use of each portion of the classification. For example, the subdivision of Psychosexual Dysfunctions into seven specific disorders is in response to the expressed needs of clinicians who specialize in the treatment of these conditions. (It soon became apparent that the criticism that a subdivision in a particular area of the classification was useless always came from clinicians who specialized

in other areas.) It should be noted, however, that the judgments of clinicians concerning the necessity for including new categories were not accepted uncritically. Although initially many new categories were added in an effort to be inclusive, experience in the field trials and lack of validity evidence from the literature resulted in the elimination of several proposed categories.

Diagnostic Criteria. Since in DSM-I, DSM-II, and ICD-9 explicit criteria are not provided, the clinician is largely on his or her own in defining the content and boundaries of the diagnostic categories. In contrast, DSM-III provides specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge diagnostic reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised.

Multiaxial Evaluation. DSM-III recommends the use of a multiaxial system for evaluation to ensure that certain information that may be of value in planning treatment and predicting outcome for each individual is recorded on each of five axes, the first three of which constitute an official diagnostic evaluation.

Axes I and II include all of the mental disorders. (Two classes of mental disorders, Personality Disorders and Specific Developmental Disorders, are assigned to Axis II, whereas all of the other mental disorders are assigned to Axis I. The reason for this is discussed on p. 23. This does not imply that these Axis II disorders are not mental disorders.)

Axis III is for physical disorders and conditions. The separation of this axis from the mental disorders axes, is based on the tradition of separating those disorders whose manifestations are primarily behavioral or psychological (i.e., mental disorders) from those whose manifestations are not. It is necessary to have a term that can be applied to all of the disorders that are not considered "mental disorders." The phrase "organic disorder" would incorrectly imply the absence of physical factors in "mental" disorders. Hence, this manual uses the term "physical disorder," recognizing that the boundaries for these two classes of disorders ("mental" and "physical" disorders) change as our understanding of the pathophysiology of these disorders increases.

Axis IV, Severity of Psychosocial Stressors and Axis V, Highest Level of Adaptive Functioning Past Year, are for use in special clinical or research settings and provide information additional to the official DSM-III diagnoses (Axes I, II, and III) that is of value for treatment planning and predicting outcome.

Hierarchical Organization of Diagnostic Classes. In some mental disorders, for example, Organic Mental Disorders, there is a wide range of signs and symptoms. In others, such as Anxiety Disorders, only a limited range of signs and symptoms is seen. For this reason, the order in which diagnostic classes are listed represents, to some extent, a hierarchy in which a disorder high in the hierarchy may have features found in disorders lower in the hierarchy, but

not the reverse. This hierarchical relationship makes it possible to present the differential diagnosis of major symptom areas in a series of decision trees (see Appendix A).

Systematic Description. The text of DSM-III systematically describes each disorder in terms of current knowledge in the following areas: essential features, associated features, age at onset, course, impairment, complications, predisposing factors, prevalence, sex ratio, familial pattern, and differential diagnosis. Although descriptively comprehensive, DSM-III is not a textbook, since it does not include information about theories of etiology, management and treatment. It should also be noted that the DSM-III classification of mental disorders does not attempt to classify disturbed dyadic, family, or other interpersonal relationships.

Glossary of Technical Terms. Technical terms used in the text for describing the disorders are defined in a glossary in Appendix B.

Annotated Comparative Listing of DSM-II and DSM-III. The profession is entitled to know the rationale for all of the major changes that have resulted in the DSM-III classification of mental disorders. For this reason, included in Appendix C is a table containing an explanation for each major change made and new category added, with references from the scientific literature. With the use of this table, the reader can more easily make the transition from the DSM-II to the DSM-III classification and understand the reasons for the changes.

NEUROTIC DISORDERS

Throughout the development of DSM-III the omission of the DSM-II diagnostic class of Neuroses has been a matter of great concern to many clinicians, and requires an explanation.

When Freud first used the term "psychoneurosis," he was referring to only four subtypes: anxiety neurosis, anxiety hysteria (phobia), obsessive compulsive neurosis, and hysteria. Freud used the term both *descriptively* (to indicate a painful symptom in an individual with intact reality testing) and to indicate the *etiological process* (unconscious conflict arousing anxiety and leading to the maladaptive use of defensive mechanisms that result in symptom formation).

At the present time, however, there is no consensus in our field as to how to define "neurosis." Some clinicians limit the term to its descriptive meaning whereas others also include the concept of a specific etiological process. To avoid ambiguity, the term *neurotic disorder* should be used only descriptively. This is consistent with the use of this term in ICD-9. The term *neurotic process*, on the other hand, should be used when the clinician wishes to indicate the concept of a specific etiological process involving the following sequence: unconscious conflicts between opposing wishes or between wishes and prohibitions, which causes unconscious perception of anticipated danger or dysphoria, which leads to use of defense mechanisms that result in either symptoms, personality disturbance, or both.

The term *neurotic disorder* thus refers to a mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing

to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact; behavior does not actively violate gross social norms (although functioning may be markedly impaired); the disturbance is relatively enduring or recurrent without treatment and is not limited to a transitory reaction to stressors; and there is no demonstrable organic etiology or factor.

Although many psychodynamically-oriented clinicians believe that the neurotic process always plays a central role in the development of neurotic disorders, there are other theories about how these disorders develop. For example, there are social learning, cognitive, behavioral, and biological models that attempt to explain the development of various neurotic disorders.

Thus, the term *neurotic disorder* is used in DSM-III without any implication of a special etiological process. Neurotic disorder, defined descriptively, is roughly equivalent to the psychoanalytic concept of "symptom neurosis." (This is distinguished from "character neurosis" which is roughly equivalent to the DSM-III concept of Personality Disorder. According to modern psychoanalytic theory, the neurotic process is involved in the development of both symptom neuroses and character neuroses.)

In DSM-III the Neurotic Disorders are included in Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders. These diagnostic classes are listed together in the DSM-III classification to facilitate the location of Neurotic Disorders. Preceding the listing of the class of Affective Disorders is a statement indicating that Neurotic Disorders are included in these five DSM-III classes.

It should be noted that the ICD-9 category Neurotic Disorders, also defined descriptively, includes only those categories that historically have been included as "neuroses" in previous standard classifications. These previous classifications did not contain some of the DSM-III categories, such as Psychosexual Disorders, that unquestionably include some disorders falling within the concept of Neurotic Disorders.

Alternative approaches to the issue of the relationship of Neurotic Disorders to the DSM-III classification were considered. If the DSM-III classification had included a category of Neurotic Disorders that was limited to those disorders included in the ICD-9 category, the potential value of the term Neurotic Disorder would have been limited by a lack of adherence to its descriptive meaning. On the other hand, to have grouped together all of the specific DSM-III categories that are usually considered to be Neurotic Disorders would have required separating some Affective Disorders from the other Affective Disorders, some Psychosexual Disorders from the other Psychosexual Disorders, and some Dissociative Disorders from other members of that class. The possible advantages of this approach seemed to be far outweighed by the disadvantage of fragmenting several diagnostic classes. Similarly, it was judged unwise to group all psychotic disorders together, as is done in ICD-9.

USING DSM-III

The major justification for the generally atheoretical approach taken in Several features are included that can help the user become adept at making

optimal use of the manual. By examining the listing of Axis I and Axis II diagnoses and conditions contained in Chapter 1, the user can become familiar with the organization of the classification into major and minor diagnostic classes. By studying Chapter 2, The Use of This Manual, the reader will learn how to use the multiaxial system, record principal and secondary diagnoses, indicate various levels of diagnostic certainty, and use the diagnostic criteria as guides in making diagnoses. Chapter 3 contains the text and criteria for all of the diagnostic categories. The user will want to pay particular attention to those sections that are most appropriate to the kind of clinical or research work that he or she does.

In making a DSM-III diagnosis the clinician may find it more convenient to consult the *Quick Reference to the Diagnostic Criteria from DSM-III*, (Mini-D), a pocket-sized booklet sold separately, that contains only the classification, the diagnostic criteria, a listing of the most important conditions to be considered in a differential diagnosis of each category, and an index. It should be noted that the index in both this book and the *Quick Reference* can be used when the clinician is in doubt about the DSM-III term that corresponds to a DSM-II term or to the name of some other widely used diagnostic category.

EVALUATION FOR TREATMENT PLANNING

Making a DSM-III diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a DSM-III diagnosis will invariably be necessary.

For instance, the clinician considering a psychodynamically-oriented treatment will pay particular attention to the nature of the interaction of the patient with the clinician during the interview, focusing on the particular way the patient molds and distorts the interview situation in order to make it conform to his or her deeply ingrained (usually unconscious) fantasies, attitudes, and expectations about interpersonal relationships. The nature of these transference phenomena will be noted in order to predict future behavior in the treatment setting and to shed light on the patient's early developmental experiences and the conflicts that underlie the current disturbance. The clinician will note the patient's ability to reflect upon feelings and fantasies as they are being experienced. The clinician will also monitor his or her own responses to the patient as an indicator of the patient's unconscious conflicts and defensive style. Finally, the clinician will make a psychodynamic diagnostic formulation that is an explanation of the patient's psychopathology in terms of the nature of the unconscious conflicts and defense mechanisms, and the origins of the current behavior in early life experience.

The clinician considering behavior therapy will do a functional analysis of the behavior disturbance. This begins by defining the problem behavior as objectively as possible in terms of developmental history and present antecedents and consequences. These may be external (environmental, social) or internal (affects, cognitions). When appropriate, attention will be paid to the patient's idiosyncratic thinking patterns (cognitions) and unfounded beliefs

about himself or herself and his or her relationship to others (schemata) which may contribute to the onset or maintenance of the problem behavior. The frequency of the problem behavior and the circumstances under which it occurs are monitored during the behavioral analysis and as treatment progresses. The functional analysis leads to the formulation of a set of hypotheses concerning the acquisition and maintenance of the problem behavior, which is then tested by the application of a specific behavioral treatment.

A clinician considering family therapy will need information about how the presenting problem affects the "identified patient" and the other family members as individuals and as a social unit, how the family members relate to each other, and how they could more effectively provide mutual support in dealing with current and future problems. In addition, the clinician will want to know how the family fits into the broader social network, which includes the therapist and other health-care providers, and how the family can make most effective use of these resources.

The clinician considering somatic therapy will pay particular attention to how any abnormalities detected during a medical examination will affect the choice of a somatic therapy. If the patient is currently on a psychoactive medication and is not responding satisfactorily, it may be useful to clarify the diagnosis and treatment needs of the patient by observing the patient without medication, making sure that this is done in circumstances that protect the patient's welfare. The patient's response to previous somatic therapy and its adequacy in terms of choice, dosage, and duration will be reviewed. The patient's attitude toward somatic treatment will be explored; and when necessary, an attempt will be made to relieve unrealistic anxieties about such treatment.

CAUTIONS

The purpose of DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for nonclinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context.

THE FUTURE

In the several years that it has taken to develop DSM-III, there have been several instances when major changes in initial drafts were necessary because of new findings. Thus, this final version of DSM-III is only one still frame in the ongoing process of attempting to better understand mental disorders.

Chapter One

The DSM-III Classification

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DSM-III CLASSIFICATION: AXES I AND II CATEGORIES AND CODES

All official DSM-III codes and terms are included in ICD-9-CM. However, in order to differentiate those DSM-III categories that use the same ICD-9-CM codes, unofficial non-ICD-9-CM codes are provided in parentheses for use when greater specificity is necessary.

The long dashes indicate the need for a fifth-digit subtype or other qualifying term.

DISORDERS USUALLY FIRST EVIDENT IN INFANCY, CHILDHOOD OR ADOLESCENCE

Mental retardation

(Code in fifth digit: 1 = with other behavioral symptoms [requiring attention or treatment and that are not part of another disorder], 0 = without other behavioral symptoms.)

317.0(x) Mild mental retardation, _____
318.0(x) Moderate mental retardation, _____
318.1(x) Severe mental retardation, _____
318.2(x) Profound mental retardation, _____
319.0(x) Unspecified mental retardation, _____

Attention deficit disorder

314.01 with hyperactivity
314.00 without hyperactivity
314.80 residual type

Conduct disorder

312.00 undersocialized, aggressive
312.10 undersocialized, nonaggressive
312.23 socialized, aggressive
312.21 socialized, nonaggressive
312.90 atypical

Anxiety disorders of childhood or adolescence

309.21 Separation anxiety disorder
313.21 Avoidant disorder of childhood or adolescence
313.00 Overanxious disorder

Other disorders of infancy, childhood or adolescence

313.89 Reactive attachment disorder of infancy
313.22 Schizoid disorder of childhood or adolescence
313.23 Elective mutism
313.81 Oppositional disorder
313.82 Identity disorder

Eating disorders

307.10 Anorexia nervosa
307.51 Bulimia
307.52 Pica
307.53 Rumination disorder of infancy
307.50 Atypical eating disorder

Stereotyped movement disorders

307.21 Transient tic disorder
307.22 Chronic motor tic disorder
307.23 Tourette's disorder
307.20 Atypical tic disorder
307.30 Atypical stereotyped movement disorder

Other disorders with physical manifestations

307.00 Stuttering
307.60 Functional enuresis
307.70 Functional encopresis
307.46 Sleepwalking disorder
307.46 Sleep terror disorder (307.49)

Pervasive developmental disorders

Code in fifth digit: 0 = full syndrome present, 1 = residual state.

299.0x Infantile autism, _____
299.9x Childhood onset pervasive developmental disorder, _____
299.8x Atypical, _____

Specific developmental disorders
Note: These are coded on Axis II.

315.00 Developmental reading disorder
315.10 Developmental arithmetic disorder
315.31 Developmental language disorder
315.39 Developmental articulation disorder
315.50 Mixed specific developmental disorder
315.90 Atypical specific developmental disorder

ORGANIC MENTAL DISORDERS
Section 1. Organic mental disorders whose etiology or pathophysiological process is listed below (taken from the mental disorders section of ICD-9-CM).

Dementias arising in the senium and presenium

Primary degenerative dementia, senile onset,
290.30 with delirium
290.20 with delusions
290.21 with depression
290.00 uncomplicated

Code in fifth digit:
1 = with delirium, 2 = with delusions, 3 = with depression, 0 = uncomplicated.
290.1x Primary degenerative dementia, presenile onset, _____
290.4x Multi-infarct dementia, _____

Substance-induced

Alcohol
303.00 intoxication
291.40 idiosyncratic intoxication
291.80 withdrawal
291.00 withdrawal delirium
291.30 hallucinosis
291.10 amnestic disorder

Code severity of dementia in fifth digit:
1 = mild, 2 = moderate, 3 = severe, 0 = unspecified.
291.2x Dementia associated with alcoholism, _____

Barbiturate or similarly acting sedative or hypnotic
305.40 intoxication (327.00)
292.00 withdrawal (327.01)
292.00 withdrawal delirium (327.02)
292.83 amnestic disorder (327.04)

Opioid
305.50 intoxication (327.10)
292.00 withdrawal (327.11)

Cocaine
305.60 intoxication (327.20)

Amphetamine or similarly acting sympathomimetic
305.70 intoxication (327.30)
292.81 delirium (327.32)
292.11 delusional disorder (327.35)
292.00 withdrawal (327.31)

Phencyclidine (PCP) or similarly acting arylcyclohexylamine
305.90 intoxication (327.40)
292.81 delirium (327.42)
292.90 mixed organic mental disorder (327.49)

Hallucinogen
305.30 hallucinosis (327.56)
292.11 delusional disorder (327.55)
292.84 affective disorder (327.57)

Cannabis
305.20 intoxication (327.60)
292.11 delusional disorder (327.65)

Tobacco
292.00 withdrawal (327.71)

Caffeine
305.90 intoxication (327.80)

Other or unspecified substance
305.90 intoxication (327.90)
292.00 withdrawal (327.91)
292.81 delirium (327.92)
292.82 dementia (327.93)
292.83 amnestic disorder (327.94)
292.11 delusional disorder (327.95)
292.12 hallucinosis (327.96)
292.84 affective disorder (327.97)
292.89 personality disorder (327.98)
292.90 atypical or mixed organic mental disorder (327.99)

Section 2. Organic brain syndromes whose etiology or pathophysiological process is either noted as an additional diagnosis from outside the mental disorders section of ICD-9-CM or is unknown.

293.00 Delirium
294.10 Dementia
294.00 Amnestic syndrome
293.81 Organic delusional syndrome
293.82 Organic hallucinosis
293.83 Organic affective syndrome
310.10 Organic personality syndrome
294.80 Atypical or mixed organic brain syndrome

SUBSTANCE USE DISORDERS

Code in fifth digit: 1 = continuous, 2 = episodic, 3 = in remission, 0 = unspecified.

305.0x Alcohol abuse, _____
303.9x Alcohol dependence (Alcoholism), _____
305.4x Barbiturate or similarly acting sedative or hypnotic abuse,
304.1x Barbiturate or similarly acting sedative or hypnotic dependence, _____
305.5x Opioid abuse, _____
304.0x Opioid dependence, _____
305.6x Cocaine abuse, _____
305.7x Amphetamine or similarly acting sympathomimetic abuse, _____
304.4x Amphetamine or similarly acting sympathomimetic dependence, _____
305.9x Phencyclidine (PCP) or similarly acting arylcyclohexylamine abuse, _____ (328.4x)
305.3x Hallucinogen abuse, _____
305.2x Cannabis abuse, _____
304.3x Cannabis dependence, _____
305.1x Tobacco dependence, _____
305.9x Other, mixed or unspecified substance abuse, _____
304.6x Other specified substance dependence, _____
304.9x Unspecified substance dependence, _____
304.7x Dependence on combination of opioid and other non-alcoholic substance, _____
304.8x Dependence on combination of substances, excluding opioids and alcohol, _____

SCHIZOPHRENIC DISORDERS

Code in fifth digit: 1 = subchronic, 2 = chronic, 3 = subchronic with acute exacerbation, 4 = chronic with acute exacerbation, 5 = in remission, 0 = unspecified.

Schizophrenia,
295.1x disorganized, _____
295.2x catatonic, _____
295.3x paranoid, _____
295.9x undifferentiated, _____
295.6x residual, _____

PARANOID DISORDERS

297.10 Paranoia
297.30 Shared paranoid disorder
298.30 Acute paranoid disorder
297.90 Atypical paranoid disorder

PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED

295.40 Schizophreniform disorder
298.80 Brief reactive psychosis
295.70 Schizoaffective disorder
298.90 Atypical psychosis

NEUROTIC DISORDERS: These are included in Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders. In order to facilitate the identification of the categories that in DSM-II were grouped together in the class of Neuroses, the DSM-II terms are included separately in parentheses after the corresponding categories. These DSM-II terms are included in ICD-9-CM and therefore are acceptable as alternatives to the recommended DSM-III terms that precede them.

AFFECTIVE DISORDERS
Major affective disorders

Code major depressive episode in fifth digit: 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 3 = with melancholia, 2 = without melancholia, 0 = unspecified.

Code manic episode in fifth digit: 6 = in remission, 4 = with psychotic features (the unofficial non-ICD-9-CM fifth digit 7 may be used instead to indicate that the psychotic features are mood-incongruent), 2 = without psychotic features, 0 = unspecified.

Bipolar disorder,
296.6x mixed, _____
296.4x manic, _____
296.5x depressed, _____

Major depression,
296.2x single episode, _____
296.3x recurrent, _____

Other specific affective disorders
301.13 Cyclothymic disorder
300.40 Dysthymic disorder (or Depressive neurosis)

Atypical affective disorders
296.70 Atypical bipolar disorder
296.82 Atypical depression

ANXIETY DISORDERS

Phobic disorders (or Phobic neuroses)
300.21 Agoraphobia with panic attacks
300.22 Agoraphobia without panic attacks
300.23 Social phobia
300.29 Simple phobia

Anxiety states (or Anxiety neuroses)
300.01 Panic disorder
300.02 Generalized anxiety disorder
300.30 Obsessive compulsive disorder (or Obsessive compulsive neurosis)

Post-traumatic stress disorder
308.30 acute
309.81 chronic or delayed

300.00 Atypical anxiety disorder

SOMATOFORM DISORDERS
300.81 Somatization disorder
300.11 Conversion disorder (or Hysterical neurosis, conversion type)
307.80 Psychogenic pain disorder
300.70 Hypochondriasis (or Hypochondriacal neurosis)
300.70 Atypical somatoform disorder (300.71)

DISSOCIATIVE DISORDERS (OR HYSTERICAL NEUROSES, DISSOCIATIVE TYPE)
300.12 Psychogenic amnesia
300.13 Psychogenic fugue
300.14 Multiple personality
300.60 Depersonalization disorder (or Depersonalization neurosis)
300.15 Atypical dissociative disorder

PSYCHOSEXUAL DISORDERS
Gender identity disorders
Indicate sexual history in the fifth digit of Transsexualism code: 1 = asexual, 2 = homosexual, 3 = heterosexual, 0 = unspecified.

302.5x Transsexualism, _____
302.60 Gender identity disorder of childhood
302.85 Atypical gender identity disorder

Paraphilias

302.81 Fetishism
302.30 Transvestism
302.10 Zoophilia
302.20 Pedophilia
302.40 Exhibitionism
302.82 Voyeurism
302.83 Sexual masochism
302.84 Sexual sadism
302.90 Atypical paraphilia

Psychosexual dysfunctions

302.71 Inhibited sexual desire
302.72 Inhibited sexual excitement
302.73 Inhibited female orgasm
302.74 Inhibited male orgasm
302.75 Premature ejaculation
302.76 Functional dyspareunia
306.51 Functional vaginismus
302.70 Atypical psychosexual dysfunction

Other psychosexual disorders

302.00 Ego-dystonic homosexuality
302.89 Psychosexual disorder not elsewhere classified

FACTITIOUS DISORDERS

300.16 Factitious disorder with psychological symptoms
301.51 Chronic factitious disorder with physical symptoms
300.19 Atypical factitious disorder with physical symptoms

DISORDERS OF IMPULSE CONTROL NOT ELSEWHERE CLASSIFIED

312.31 Pathological gambling
312.32 Kleptomania
312.33 Pyromania
312.34 Intermittent explosive disorder
312.35 Isolated explosive disorder
312.39 Atypical impulse control disorder

ADJUSTMENT DISORDER

309.00 with depressed mood
309.24 with anxious mood
309.28 with mixed emotional features
309.30 with disturbance of conduct
309.40 with mixed disturbance of emotions and conduct
309.23 with work (or academic) inhibition
309.83 with withdrawal
309.90 with atypical features

PSYCHOLOGICAL FACTORS AFFECTING PHYSICAL CONDITION

Specify physical condition on Axis III.
316.00 Psychological factors affecting physical condition

PERSONALITY DISORDERS
Note: These are coded on Axis II.

301.00 Paranoid
301.20 Schizoid
301.22 Schizotypal
301.50 Histrionic
301.81 Narcissistic
301.70 Antisocial
301.83 Borderline
301.82 Avoidant
301.60 Dependent
301.40 Compulsive
301.84 Passive-Aggressive
301.89 Atypical, mixed or other personality disorder

V CODES FOR CONDITIONS NOT ATTRIBUTABLE TO A MENTAL DISORDER THAT ARE A FOCUS OF ATTENTION OR TREATMENT

V65.20 Malingering
V62.89 Borderline intellectual functioning (V62.88)
V71.01 Adult antisocial behavior
V71.02 Childhood or adolescent antisocial behavior
V62.30 Academic problem
V62.20 Occupational problem
V62.82 Uncomplicated bereavement
V15.81 Noncompliance with medical treatment
V62.89 Phase of life problem or other life circumstance problem
V61.10 Marital problem
V61.20 Parent-child problem
V61.80 Other specified family circumstances
V62.81 Other interpersonal problem

ADDITIONAL CODES

300.90 Unspecified mental disorder (nonpsychotic)
V71.09 No diagnosis or condition on Axis I
799.90 Diagnosis or condition deferred on Axis I

V71.09 No diagnosis on Axis II
799.90 Diagnosis deferred on Axis II

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Chapter Two

Use of This Manual

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Use of This Manual

MULTIAXIAL EVALUATION

A multiaxial evaluation requires that every case be assessed on each of several "axes," each of which refers to a different class of information. In order for the system to have maximal clinical usefulness, there must be a limited number of axes; there are five in the DSM-III multiaxial classification. The first three axes constitute the official diagnostic assessment.

Each individual is evaluated on each of these axes:

Axis I	Clinical Syndromes Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment Additional Codes
Axis II	Personality Disorders Specific Developmental Disorders
Axis III	Physical Disorders and Conditions

Axes IV and V are available for use in special clinical and research settings and provide information supplementing the official DSM-III diagnoses (Axes I, II, and III) that may be useful for planning treatment and predicting outcome:

Axis IV	Severity of Psychosocial Stressors
Axis V	Highest Level of Adaptive Functioning Past Year

Use of the DSM-III multiaxial classification ensures that attention is given to certain types of disorders, aspects of the environment, and areas of functioning that might be overlooked if the focus were on assessing a single presenting problem.

Axes I and II

Axes I and II comprise the entire classification of mental disorders plus Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment. The disorders listed on Axis II are the Personality Disorders (for adults and, in some cases, for children and adolescents) and the Specific Developmental Disorders (for children and adolescents and, in some cases, for adults). The remaining disorders and conditions are included in Axis I. This separation ensures that consideration is given to the possible presence of disorders that are frequently overlooked when attention is directed to the usually more florid Axis I disorder.

In some instances an individual may have a disorder on both axes. For exam-

ple, an adult may have Major Depression noted on Axis I and Compulsive Personality Disorder on Axis II, or a child may have Conduct Disorder noted on Axis I and Developmental Language Disorder on Axis II. In other instances there may be no disorder on Axis I, the reason for seeking treatment being limited to a condition noted on Axis II. In this latter case, the clinician should write: *Axis I:* V71.09 No diagnosis or condition on Axis I. On the other hand, if a disorder is noted on Axis I but there is no evidence of an Axis II disorder, the clinician should write: *Axis II:* V71.09 No diagnosis on Axis II, or one of the Conditions Not Attributable to a Mental Disorder should be recorded.

Multiple diagnoses within Axes I and II

On both Axes I and II, multiple diagnoses should be made when necessary to describe the current condition. This applies particularly to Axis I, in which, for example, an individual may have both a Substance Use Disorder and an Affective Disorder. It is possible to have multiple diagnoses within the same class. For example, it is possible to have several Substance Use Disorders or, in the class of Affective Disorders, it is possible to have Major Depression superimposed on Dysthymic Disorder or Bipolar Disorder superimposed on Cyclothymic Disorder. In other classes, such as Schizophrenic Disorders, however, each of the subtypes is mutually exclusive.

Within Axis II, the diagnosis of multiple Specific Developmental Disorders is common. For some adults the persistence of a Specific Developmental Disorder and the presence of a Personality Disorder may require that both be noted on Axis II. Usually, a single Personality Disorder will be noted; but when the individual meets the criteria for more than one, all should be recorded.

Axis II and description of personality features

Axis II can be used to indicate specific personality traits when no Personality Disorder exists. For example, compulsive traits can be recorded on Axis II for an individual for whom Major Depression is noted on Axis I. Even when a Personality Disorder is noted on Axis II, the clinician may wish to indicate other personality characteristics—e.g., paranoid traits can be noted on Axis II for an individual who is also described as having Compulsive Personality Disorder on this same axis. (Code numbers should not be used when personality *traits* are noted, since a code number indicates a Personality *Disorder*.)

Principal diagnosis

When an individual receives more than one diagnosis, the *principal* diagnosis is the condition that was chiefly responsible for occasioning the evaluation or admission to clinical care. In most cases this condition will be the main focus of attention or treatment. The principal diagnosis may be an Axis I or an Axis II diagnosis; but when an Axis II diagnosis is the principal diagnosis the notation should be followed by the phrase "(Principal diagnosis)."

Example:	Axis I:	303.93	Alcohol Dependence, In Remission
	Axis II:	301.70	Antisocial Personality Disorder (Principal diagnosis)

When an individual has both an Axis I and an Axis II diagnosis, the principal diagnosis will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "(Principal diagnosis)."

When multiple diagnoses are made on either Axis I or Axis II, they should be listed within each axis in the order of focus of attention or treatment. For example, if an individual with Schizophrenia, Paranoid Type, Chronic, comes to an emergency room for treatment of Alcohol Intoxication, the diagnosis should be listed:

Axis I:	303.00	Alcohol Intoxication
	295.32	Schizophrenia, Paranoid Type, Chronic

Provisional diagnosis

In some instances not enough information will be available to make a firm diagnosis. The clinician may wish to indicate a significant degree of diagnostic uncertainty by writing "(Provisional)" following the diagnosis—e.g., Schizophreniform Disorder (Provisional, rule out Organic Delusional Syndrome).

Levels of diagnostic certainty

Frequently a diagnostic evaluation yields insufficient information to make a specific diagnosis. The following table indicates the various ways in which a clinician may indicate diagnostic uncertainty:

Term	Examples of clinical situations
V Codes (for Conditions Not Attributable to a Mental Disorder That Are a Focus of Attention or Treatment)	Insufficient information to know whether or not a presenting problem is attributable to a mental disorder, e.g., Academic Problem; Adult Antisocial Behavior.
799.90 Diagnosis or Condition Deferred on Axis I	Information inadequate to make any diagnostic judgment about an Axis I diagnosis or condition.
799.90 Diagnosis Deferred on Axis II	Same for an Axis II diagnosis.
300.90 Unspecified Mental Disorder (non-psychotic)	Enough information available to rule out a psychotic disorder, but further specification is not possible.
298.90 Atypical Psychosis	Enough information available to determine the presence of a psychotic disorder, but further specification is not possible.

Term	Examples of clinical situations
Atypical (class of disorder)	Enough information available to indicate the class of disorder that is present, but further specification is not possible, because either there is not sufficient information to make a more specific diagnosis, or the clinical features of the disorder do not meet the criteria for any of the other categories, e.g., Atypical Affective Disorder.
Specific diagnosis (Provisional)	Enough information available to make a "working" diagnosis, but the clinician wishes to indicate a significant degree of diagnostic uncertainty, e.g., Schizophreniform Disorder (Provisional).

Axis III. Physical Disorders or Conditions

Axis III permits the clinician to indicate any current physical disorder or condition that is potentially relevant to the understanding or management of the individual. These are the conditions outside of the mental disorders section of ICD-9-CM. In some instances the condition may be etiologically significant (e.g., a neurologic disorder associated with Dementia); in other instances the physical disorder may not be etiologic, but important in the overall management of the individual (e.g., diabetes in a child with a Conduct Disorder). In yet other instances, the clinician may wish to note significant associated physical findings, such as "soft neurological signs." Multiple diagnoses are permitted.

Axis IV. Severity of Psychosocial Stressors

Axis IV provides a coding of the overall severity of a stressor judged to have been a significant contributor to the development or exacerbation of the current disorder. An individual's prognosis may be better when a disorder develops as a consequence of a severe stressor than when it develops after no stressor or a minimal stressor.

Rating the severity of the stressor. This rating should be based on the clinician's assessment of the stress an "average" person in similar circumstances and with similar sociocultural values would experience from the particular psychosocial stressor(s). This judgment involves consideration of the following: the amount of change in the individual's life caused by the stressor, the degree to which the event is desired and under the individual's control, and the number of stressors. Even though a specific stressor may have greater impact on an individual who is especially vulnerable or has certain internal conflicts, the rating should be based on the severity of the stressor itself, not on the individual's vulnerability to the particular stressor. If a vulnerability to stress exists, it will frequently be due to a mental disorder that is coded on Axis I or II.

In most instances the psychosocial stressor will have occurred within a year prior to the current disorder (Post-traumatic Stress Disorder is a notable exception). In some instances the stressor is the anticipation of a future event: for example, the knowledge that one will soon retire. Although a stressor frequently

plays a precipitating role in a disorder, it may also be a consequence of the individual's psychopathology—e.g., Alcohol Dependence may lead to marital problems and divorce, which can then become stressors contributing to the development of a Major Depression. The current disorder that is related to the psychosocial stressor may be either a clinical syndrome, coded on Axis I, or an exacerbation of a Personality or Specific Developmental Disorder, coded on Axis II.

In addition to the severity rating, in certain settings it may be useful to note the specific psychosocial stressor (e.g., chronic marital discord about sharing household duties). This information may be important in formulating a treatment plan that includes attempts to remove the psychosocial stressor or to help the individual cope with it. More than one psychosocial stressor may be judged etiologically significant by the clinician, but rarely will more than four be recorded. The stressors should be noted as specifically as possible and listed in order of their importance.

The severity rating should reflect the summed effect of all of the psychosocial stressors that are listed. The following codes and terms may be used as guides in making the rating:

Code	Term	Adult examples	Child or adolescent examples
1	None	No apparent psychosocial stressor	No apparent psychosocial stressor
2	Minimal	Minor violation of the law; small bank loan	Vacation with family
3	Mild	Argument with neighbor; change in work hours	Change in schoolteacher; new school year
4	Moderate	New career; death of close friend; pregnancy	Chronic parental fighting; change to new school; illness of close relative; birth of sibling
5	Severe	Serious illness in self or family; major financial loss; marital separation; birth of child	Death of peer; divorce of parents; arrest; hospitalization; persistent and harsh parental discipline
6	Extreme	Death of close relative; divorce	Death of parent or sibling; repeated physical or sexual abuse
7	Catastrophic	Concentration camp experience; devastating natural disaster	Multiple family deaths
0	Unspecified	No information, or not applicable	No information, or not applicable

Types of psychosocial stressors to be considered. To ascertain etiologically significant psychosocial stressors, the following areas may be considered:

Conjugal (marital and nonmarital): e.g., engagement, marriage, discord, separation, death of spouse.

Parenting: e.g., becoming a parent, friction with child, illness of child.

Other interpersonal: problems with one's friends, neighbors, associates, or nonconjugal family members, e.g., illness of best friend, discordant relationship with boss.

Occupational: includes work, school, homemaker, e.g., unemployment, retirement, school problems.

Living circumstances: e.g., change in residence, threat to personal safety, immigration.

Financial: e.g., inadequate finances, change in financial status.

Legal: e.g., arrested, jailed, lawsuit or trial.

Developmental: phases of the life cycle, e.g., puberty, transition to adult status, menopause, "becoming 50."

Physical illness or injury: e.g., illness, accident, surgery, abortion. (*Note:* A physical disorder is listed on Axis III whenever it is related to the development or management of an Axis I or II disorder. A physical disorder can also be a psychosocial stressor if its impact is due to its meaning to the individual, in which case it would be listed on both Axis III and Axis IV.)

Other psychosocial stressors: e.g., natural or manmade disaster, persecution, unwanted pregnancy, out-of-wedlock birth, rape.

Family factors (children and adolescents): In addition to the above, for children and adolescents the following stressors may be considered: cold or distant relationship between parents; overtly hostile relationship between parents; physical or mental disturbance in family members; cold or distant parental behavior toward child; overtly hostile parental behavior toward child; parental intrusiveness; inconsistent parental control; insufficient parental control; insufficient social or cognitive stimulation; anomalous family situation, e.g., single parent, foster family; institutional rearing; loss of nuclear family members.

Axis V. Highest Level of Adaptive Functioning Past Year

Axis V permits the clinician to indicate his or her judgment of an individual's highest level of adaptive functioning (for at least a few months) during the past year. This information frequently has prognostic significance, because usually an individual returns to his or her previous level of adaptive functioning after an episode of illness.

As conceptualized here, adaptive functioning is a composite of three major areas: social relations, occupational functioning, and use of leisure time. These three areas are to be considered together, although there is evidence that social relations should be given greater weight because of their particularly great prognostic significance. An assessment of the use of leisure time will affect the overall judgment only when there is no significant impairment in social relations and occupational functioning or when occupational opportunities are limited or absent (e.g., the individual is retired or handicapped).

Social relations include all relations with people, with particular emphasis on family and friends. The breadth and quality of interpersonal relationships should be considered.

Occupational functioning refers to functioning as a worker, student, or homemaker. The amount, complexity, and quality of the work accomplished

should be considered. The highest levels of adaptive functioning should be used only when high occupational productivity is not associated with a high level of subjective discomfort.

Use of leisure time includes recreational activities or hobbies. The range and depth of involvement and the pleasure derived should be considered.

The level noted should be descriptive of the individual's functioning regardless of whether or not special circumstances, such as concurrent treatment, may have been necessary to sustain that level.

Levels	Adult examples	Child or adolescent examples
1 SUPERIOR—Unusually effective functioning in social relations, occupational functioning, and use of leisure time.	Single parent living in deteriorating neighborhood takes excellent care of children and home, has warm relations with friends, and finds time for pursuit of hobby.	A 12-year-old girl gets superior grades in school, is extremely popular among her peers, and excels in many sports. She does all of this with apparent ease and comfort.
2 VERY GOOD—Better than average functioning in social relations, occupational functioning, and use of leisure time.	A 65-year-old retired widower does some volunteer work, often sees old friends, and pursues hobbies.	An adolescent boy gets excellent grades, works part-time, has several close friends, and plays banjo in a jazz band. He admits to some distress in "keeping up with everything."
3 GOOD—No more than slight impairment in either social or occupational functioning.	A woman with many friends functions extremely well at a difficult job, but says "the strain is too much."	An 8-year-old boy does well in school, has several friends, but bullies younger children.
4 FAIR—Moderate impairment in either social relations or occupational functioning, *or* some impairment in both.	A lawyer has trouble carrying through assignments; has several acquaintances, but hardly any close friends.	A 10-year-old girl does poorly in school, but has adequate peer and family relations.
5 POOR—Marked impairment in either social relations or occupational functioning, *or* moderate impairment in both.	A man with one or two friends has trouble keeping a job for more than a few weeks.	A 14-year-old boy almost fails in school and has trouble getting along with his peers.

Levels	Adult examples	Child or adolescent examples
6 VERY POOR—Marked impairment in both social relations and occupational functioning.	A woman is unable to do any of her housework and has violent outbursts toward family and neighbors.	A 6-year-old girls needs special help in all subjects and has virtually no peer relationships.
7 GROSSLY IMPAIRED—Gross impairment in virtually all areas of functioning.	An elderly man needs supervision to maintain minimal personal hygiene and is usually incoherent.	A 4-year-old boy needs constant restraint to avoid hurting himself and is almost totally lacking in skills.
0 UNSPECIFIED	No information.	No information.

Examples of How To Record the Results of a DSM-III Multiaxial Evaluation

EXAMPLE 1

Axis I: 296.23 Major Depression, Single Episode, with Melancholia
303.93 Alcohol Dependence, In Remission

Axis II: 301.60 Dependent Personality Disorder (Provisional, rule out Borderline Personality Disorder)

Axis III: Alcoholic cirrhosis of liver

Axis IV: Psychosocial stressors: anticipated retirement and change in residence with loss of contact with friends
Severity: 4—Moderate

Axis V: Highest level of adaptive functioning past year: 3—Good

EXAMPLE 2

Axis I: 304.03 Heroin Dependence, In Remission

Axis II: 301.70 Antisocial Personality Disorder (Principal diagnosis); prominent paranoid traits

Axis III: None

Axis IV: Psychosocial stressors: No information
Severity: 0—Unspecified

Axis V: Highest level of adaptive functioning past year: 5—Poor

EXAMPLE 3

Axis I: 295.92 Schizophrenia, Undifferentiated Type, Chronic
V62.89 Borderline Intellectual Functioning (Provisional)

Axis II: V71.08 No diagnosis on Axis II

Axis III: Late effects of viral encephalitis

Axis IV: Psychosocial stressors: death of mother
Severity: 6—Extreme

Axis V: Highest level of adaptive functioning past year: 6—Very poor

DIAGNOSTIC CRITERIA

Diagnostic criteria appear at the end of the text describing each specific diagnosis.

These criteria are offered as useful guides for making the diagnosis, since it has been demonstrated that the use of such criteria enhances diagnostic agreement among clinicians. It should be understood, however, that for most of the categories the criteria are based on clinical judgment, and have not yet been fully validated; with further experience and study, the criteria will, in many cases, undoubtedly be revised.

Designation by capital letters indicates multiple criteria the presence of *all* of which constitutes the guide to making the diagnosis.

TYPES OF INFORMATION IN THE TEXT

In order to ensure consistency and comprehensiveness in the descriptions of the disorders, information has been included under each of the following headings. In some instances, when many of the specific disorders, such as Substance Use Disorders, share common features, this information is included in the introduction to the entire section.

The first paragraph states the **essential features** of the disorder. These are the features that are generally required to make the diagnosis and that are always present.

Associated features. Features that are often, but not invariably, present.

Age at onset. The age when the disorder usually becomes apparent.

Course. The usual course or outcome of the disorder.

Impairment. Conceptualized primarily as impairment in social and occupational functioning.

Complications. Disorders or events (e.g., suicide) that may develop as a result of the disorder. In some cases the distinction among complications, impairment, and associated features is arbitrary.

Predisposing factors. Characteristics of an individual that can be identified before the development of the disorder and that place him or her at higher risk for developing the disorder. Not included in this section are general societal or environmental conditions (such as poverty) that may predispose all individuals exposed to these conditions to develop the disorder.

Prevalence. The prevalence of the disorder is often expressed as the proportion of adults who at some time in their lives met the criteria for the disorder. This method of presentation has the advantage of being readily understandable, but it is highly dependent on the age at onset and the relative proportion of individuals in the population who have reached that age. The data are often presented as a range, based on more than a single study.

When data from epidemiological studies are not available, the prevalence is stated in general terms preceded by the word "apparently" to indicate that the judgment is based on clinical experience. The term "apparently rare" is applied to disorders that may not be seen by a clinician in many years of practice.

Sex ratio. The relative frequency with which the disorder is diagnosed in men and women.

Familial pattern. Indication of whether the disorder is more common among biologically related family members than in the general population. When this is the case, it does not necessarily indicate a genetic mechanism. Unless positive information has been replicated in several studies, "No information" is noted.

Differential diagnosis. Disorders that should be distinguished from the one being presented are discussed, generally in the order in which they appear in the classification.

EXPLANATION OF TERMS AND CONVENTIONS

Atypical. This term is used to indicate a category within a class of disorders that is residual to the specific categories in that class, although it is recognized that in some settings what is regarded as an atypical disorder may actually be more common than any of the specific disorders in that particular class. (In the literature the term "atypical" has sometimes been used in a different sense—to describe a specific diagnostic category that has unusual features.)

Physical disorders. The term "physical disorders" is used to refer to any disorder listed in ICD-9-CM outside the chapter on mental disorders.

Terms in parentheses. In order to facilitate the identification of the categories that in DSM-II were grouped together in the class of Neuroses, the DSM-II terms are included separately in parentheses after the corresponding categories. These DSM-II terms are included in ICD-9-CM and therefore are acceptable as alternatives to the recommended DSM-III terms that precede them.

Not due to another disorder. This phrase is used to indicate that the disorder being described is not diagnosed if the disturbance is apparently symptomatic of another disorder. For example, in the diagnostic criteria for Schizophrenia, there is the phrase, "Not due to any Organic Mental Disorder." This means that the diagnosis of Schizophrenia is not given if the characteristic symptoms, such as delusions or hallucinations, are caused by an Organic Mental Disorder.

Chapter Three

The Diagnostic Categories: Text and Criteria

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Disorders Usually First Evident In Infancy, Childhood, Or Adolescence

The disorders described in this chapter are those that usually arise and are first evident in infancy, childhood, or adolescence. (Exceptions are the Gender Identity Disorders, classified with the other Psychosexual Disorders.) There is no arbitrary age limit here that defines childhood and adolescence, and this section includes some disorders characteristic of older adolescents, such as Identity Disorder, which may first appear in early adulthood.

In diagnosing an infant, child, or adolescent, the clinician should first consider the diagnoses included in this section. If an appropriate diagnosis cannot be found, disorders described elsewhere in this manual should be considered.

Because the *essential* features of Affective Disorders and Schizophrenia are the same in children and adults, there are no special categories corresponding to these disorders in this section of the classification. For example, if a child or adolescent has an illness that meets the criteria for Major Depression, Dysthymic Disorder, or Schizophrenia, these diagnoses should be given, regardless of the age of the individual. (In some instances, age-specific *associated* features that apply to infants, children, or adolescents are included in the text.)

Other diagnostic categories that often will be appropriate for children or adolescents are the following:

Organic Mental Disorders
Substance Use Disorders
Schizophrenic Disorders
Affective Disorders
Schizophreniform Disorder
Anxiety Disorders
Somatoform Disorders
Personality Disorders*
Psychosexual Disorders
Adjustment Disorder
Psychological Factors Affecting Physical Condition

Adults should be given diagnoses from this section if, as infants, children, or adolescents, they manifested any of these conditions and if the condition has persisted. Examples include Attention Deficit Disorder, Residual Type, and some cases of Conduct Disorder. Finally, some individuals may develop in adulthood a disorder, such as Anorexia Nervosa, that is included in this section because the disorder *usually* develops in children or adolescents.

The classes of disorders described in this section can be separated into five major groups on the basis of the predominant area of disturbance. This subgrouping is done for heuristic purposes, and it is recognized that the designation of the area of predominant disturbance is at best an approximation.

I. Intellectual
   Mental Retardation

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* For a discussion of the diagnosis of Personality Disorders in children and adolescents, see p. 305.

II. Behavioral (overt)
  Attention Deficit Disorder
  Conduct Disorder

III. Emotional
  Anxiety Disorders of Childhood or Adolescence
  Other Disorders of Infancy, Childhood, or Adolescence

IV. Physical
  Eating Disorders
  Stereotyped Movement Disorders
  Other Disorders with Physical Manifestations

V. Developmental
  Pervasive Developmental Disorders
  Specific Developmental Disorders

Children often have problems in development that are not subsumed within the specific DSM-III diagnostic categories, such as precocious sexual activity and aggressive behavior. In these cases a diagnosis of Unspecified Mental Disorder may be used, and the predominant features should be described. Similarly, many children have problems that do not warrant diagnosis as a mental disorder. Such conditions can be noted with a V code, such as Parent-Child Problem, Childhood or Adolescent Antisocial Behavior, or Other Specified Family Circumstances.

A category for child abuse is not included in DSM-III as a mental disorder (of the abusing parent) since child abuse as an act can be a symptom of many different disorders or not be associated with any mental disorder. Child abuse is not included as a separate V code because, when not due to a mental disorder, it represents merely one of many types of family circumstances that can be coded as V61.80, Other Specified Family Circumstances. (In ICD-9-CM, there is a special code, V61.21, Child Abuse, that refers to the situation of child abuse involving child, parent or both. The code 995.5, Child Maltreatment Syndrome, identifies the abused child who presents with injuries or other trauma.)

MENTAL RETARDATION*

The essential features are: (1) significantly subaverage general intellectual functioning, (2) resulting in, or associated with, deficits or impairments in adaptive behavior, (3) with onset before the age of 18. The diagnosis is made regardless of whether or not there is a coexisting mental or physical disorder.

General intellectual functioning is defined as an intelligence quotient (IQ) obtained by assessment with one or more of the individually administered general intelligence tests. Significantly subaverage intellectual functioning is defined as an IQ of 70 or below on an individually administered IQ test. Since any measurement is fallible, an IQ score is generally thought to involve an error of measurement of approximately five points; hence, an IQ of 70 is considered to represent a band or zone of 65 to 75. Treating the IQ with some flexibility permits the inclusion in the Mental Retardation category of individuals with IQs some-

* The definitions of Mental Retardation were written in accordance with the terminology and classification of the American Association on Mental Deficiency.

what higher than 70 who truly need special education or other programs. It also permits exclusion from the diagnosis of those with IQs somewhat lower than 70 if the clinical judgment is that there are no significant deficits or impairment in adaptive functioning.

Adaptive behavior refers to the effectiveness with which an individual meets the standards of personal independence and social responsibility expected of his or her age and cultural group. There are scales designed to quantify adaptive behavior, but none is considered sufficiently reliable and valid to be used alone to evaluate this aspect of functioning. Therefore, clinical judgment is necessary for the assessment of general adaptation, the individual's age being taken into consideration. The IQ level of 70 was chosen as the upper limit for Mental Retardation because most people with IQs below 70 are so limited in their adaptive functioning that they require special services and protection, particularly during the school-age years.

The arbitrary IQ ceiling values are based on data indicating a positive association between intelligence (as measured by IQ score) and adaptive behavior. This association declines at the upper levels of Mild Retardation. Some individuals with an IQ near but below 70 may not have the impairment in adaptive behavior required for a diagnosis of Mental Retardation.

When the clinical picture develops for the first time after the age of 18, the syndrome is a Dementia, not Mental Retardation, and is coded within the Organic Mental Disorders section of the classification (p. 162). When the clinical picture develops before the age of 18 in an individual who previously had normal intelligence, Mental Retardation and Dementia should *both* be diagnosed.

Etiologic factors may be primarily biological, psychosocial, or an interaction of both. When a known biological factor is present, the specific biological condition should be noted on Axis III.

Associated features. The prevalence of other mental disorders, such as Stereotyped Movement Disorder, Infantile Autism, and Attention Deficit Disorder with Hyperactivity, is three or four times greater among children with Mental Retardation than in the general population. When another mental disorder is present, it should also be coded on Axis I.

There may be no associated behavioral features other than those reflecting the Mental Retardation itself, as in some cases of Down's syndrome, or there may be other behavioral concomitants, such as irritability, aggressivity, temper tantrums, or stereotyped movements. (When these other behavioral symptoms require attention or treatment, their presence may be noted in the fifth digit, p. 41).

Often there are multiple neurological abnormalities, involving neuromuscular function, vision or hearing, or seizures, particularly among individuals with Severe Mental Retardation. These should be noted on Axis III.

Course. When a specific biological abnormality is present, the course is usually chronic and without remission, and without treatment the disorder may become more severe. In mild forms of the disorder with no known etiology, the course may be self-limited as the individual experiences an increase in intellec-

tual functioning (e.g., from a more stimulating environment) or displays more adaptive behavior (e.g., outside of the demanding environment of school to which he or she was unable to adapt).

Impairment. By definition, there are always deficits or impairments in adaptive functioning. The degree of impairment is correlated with the level of general intellectual functioning and the presence of the associated features noted above.

Complications. The major complication is inability to function independently and hence a continuing need for supervision and financial support.

Etiologic factors and familial pattern. Etiologic factors may be primarily biological, psychosocial, or an interaction of both. In 25% of the cases, the etiologic factors are known biological abnormalities, the most common being chromosomal and metabolic disorders such as Down's syndrome and phenylketonuria. In such cases the diagnosis is usually established at birth or at a relatively young age, and the severity of the Mental Retardation is generally moderate to profound. Heavy maternal alcohol consumption during pregnancy can cause the fetal alcohol syndrome, manifested by retarded growth, various craniofacial and limb anomalies, and Mental Retardation.

Mental Retardation due to known biological factors is as likely to occur among children of upper socioeconomic classes as among those of lower socioeconomic classes. In such cases there is no increased prevalence of Mental Retardation in other family members unless the underlying biological condition is a genetically determined disorder, such as phenylketonuria or Tay-Sachs disease.

In the remaining 75% of the cases, no known specific biological factor accounts for the disorder; the level of intellectual impairment is usually mild, with IQs between 50 and 70; and the diagnosis is commonly not made until school entrance. The lower socioeconomic classes are overrepresented in these cases of Mental Retardation; the significance of this is not clear. There is often a familial pattern of similar degrees of severity of Mental Retardation in parents and siblings.

Mental Retardation without known biological etiology may be associated with psychosocial deprivation of various types, such as deprivation of social, linguistic, and intellectual stimulation. However, the specific etiology of these forms of Mental Retardation is unknown. Three sets of etiologic factors are probably involved, either singly or in combination: genetic factors, environmental biological factors such as malnutrition, and early child-rearing experiences.

Prevalence. At any one point in time, approximately 1% of the population meets the criteria for Mental Retardation.

Sex ratio. The disorder is nearly twice as common among males as among females.

Subtypes. There are four subtypes, reflecting the degree of intellectual im-

pairment and designated as Mild, Moderate, Severe, and Profound. IQ levels to be used as guides for distinguishing the four subtypes are given below:

Subtypes of Mental Retardation	IQ Levels
Mild	50-70
Moderate	35-49
Severe	20-34
Profound	Below 20

317.0(x) Mild Mental Retardation

Mild Mental Retardation is roughly equivalent to the educational category "educable." This group makes up the largest segment of those with the disorder—about 80%. Individuals with this level of Mental Retardation can develop social and communication skills during the preschool period (ages 0-5), have minimal impairment in sensorimotor areas, and often are not distinguishable from normal children until a later age. By their late teens they can learn academic skills up to approximately the sixth-grade level; and during the adult years, they can usually achieve social and vocational skills adequate for minimum self-support, but may need guidance and assistance when under unusual social or economic stress.

318.0(x) Moderate Mental Retardation

Moderate Mental Retardation is roughly equivalent to the educational category of "trainable." This group makes up 12% of the entire population of individuals with Mental Retardation. Those with this level of Mental Retardation during the preschool period can talk or learn to communicate, but they have only poor awareness of social conventions. They may profit from vocational training and can take care of themselves with moderate supervision. During the school-age period, they can profit from training in social and occupational skills, but are unlikely to progress beyond the second-grade level in academic subjects. They may learn to travel alone in familiar places. During their adult years they may be able to contribute to their own support by performing unskilled or semiskilled work under close supervision in sheltered workshops. They need supervision and guidance when under mild social or economic stress.

318.1(x) Severe Mental Retardation

This group makes up 7% of individuals with Mental Retardation. During the preschool period there is evidence of poor motor development and minimal speech, and they develop little or no communicative speech. During the school-age period, they may learn to talk and can be trained in elementary hygiene skills. They are generally unable to profit from vocational training. During their adult years they may be able to perform simple work tasks under close supervision.

318.2(x) Profound Mental Retardation

This group constitutes less than 1% of individuals with Mental Retardation. During the preschool period these children display minimal capacity for sensori-

motor functioning. A highly structured environment, with constant aid and supervision, is required. During the school-age period, some further motor development may occur and the children may respond to minimal or limited training in self-care. Some speech and further motor development may take place during the adult years, and very limited self-care may be possible, in a highly structured environment with constant aid and supervision.

319.0(x) Unspecified Mental Retardation

This category should be used when there is a strong presumption of Mental Retardation but the individual is untestable by standard intelligence tests. This may be the case when children, adolescents or adults are too impaired or uncooperative to be tested. In the case of infants, since the available tests, such as the Bayley, Cattel, and others, do not yield numerical IQ values, this may be the case when there is a clinical judgment of significant subaverage intellectual functioning. In general, the younger the age, the more difficult it is to make a diagnosis of Mental Retardation, except for those with profound impairment.

This category should not be used when the intellectual level is presumed to be above 70 (see V code for Borderline Intellectual Functioning, p. 332).

Differential diagnosis. The diagnosis of Mental Retardation should be made whenever present regardless of the presence of another diagnosis. In **Specific Developmental Disorders** there is a delay or failure of development in a specific area, such as reading or language, but in other areas of development the child is developing normally. In contrast, the child with Mental Retardation shows general delays in development in many areas. In **Pervasive Developmental Disorders** there are distortions in the timing, rate, and sequence of many basic psychological functions involved in the development of social skills and language. Furthermore, there are severe qualitative abnormalities that are not normal for any stage of development, whereas in Mental Retardation there are generalized delays in development, but the children behave as if they were passing through an earlier normal developmental stage. Mental Retardation may, however, coexist with Specific Developmental Disorders, and frequently coexists with Pervasive Developmental Disorders.

The V code **Borderline Intellectual Functioning** is given when there are deficits in adaptive behavior associated with borderline intellectual functioning, which generally is in the IQ range of 71 to 84. Differentiating Mild Mental Retardation from Borderline Intellectual Functioning requires careful consideration of all available information, including psychological test scores.

Diagnostic criteria for Mental Retardation

A. Significantly subaverage general intellectual functioning: an IQ of 70 or below on an individually administered IQ test (for infants, since available intelligence tests do not yield numerical values, a clinical judgment of significant subaverage intellectual functioning).

B. Concurrent deficits or impairments in adaptive behavior, taking the person's age into consideration.

C. Onset before the age of 18.

(If there are behavioral symptoms requiring attention or treatment [e.g., aggressive behavior, self-mutilation, anxiety symptoms] that are not part of another disorder, the non-ICD-9-CM code "1" may be recorded in the fifth digit. Otherwise, code "0".)

ATTENTION DEFICIT DISORDER

The essential features are signs of developmentally inappropriate inattention and impulsivity. In the past a variety of names have been attached to this disorder, including: Hyperkinetic Reaction of Childhood, Hyperkinetic Syndrome, Hyperactive Child Syndrome, Minimal Brain Damage, Minimal Brain Dysfunction, Minimal Cerebral Dysfunction, and Minor Cerebral Dysfunction. In this manual Attention Deficit is the name given to this disorder, since attentional difficulties are prominent and virtually always present among children with these diagnoses. In addition, though excess motor activity frequently diminishes in adolescence, in children who have the disorder, difficulties in attention often persist.

There are two subtypes of the active disorder, Attention Deficit Disorder with Hyperactivity, and Attention Deficit Disorder without Hyperactivity, although it is not known whether they are two forms of a single disorder or represent two distinct disorders. Finally, there is a residual subtype for individuals once diagnosed as having Attention Deficit Disorder with Hyperactivity in which hyperactivity is no longer present, but other signs of the disorder persist.

314.01 Attention Deficit Disorder with Hyperactivity

The essential features are signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. In the classroom, attentional difficulties and impulsivity are evidenced by the child's not staying with tasks and having difficulty organizing and completing work. The children often give the impression that they are not listening or that they have not heard what they have been told. Their work is sloppy and is performed in an impulsive fashion. On individually administered tests, careless, impulsive errors are often present. Performance may be characterized by oversights, such as omissions or insertions, or misinterpretations of easy items even when the child is well motivated, not just in situations that hold little intrinsic interest. Group situations are particularly difficult for the child, and attentional difficulties are exaggerated when the child is in the classroom, where sustained attention is expected.

At home, attentional problems are shown by a failure to follow through on parental requests and instructions and by the inability to stick to activities, including play, for periods of time appropriate for the child's age.

Hyperactivity in young children is manifested by gross motor activity, such as excessive running or climbing. The child is often described as being on the go, "running like a motor," and having difficulty sitting still. Older children and adolescents may be extremely restless and fidgety. Often it is the quality of the motor behavior that distinguishes this disorder from ordinary overactivity in that hyperactivity tends to be haphazard, poorly organized, and not goal-directed.

In situations in which high levels of motor activity are expected and appro-

priate, such as on the playground, the hyperactivity seen in children with this disorder may not be obvious.

Typically, the symptoms of this disorder in any given child vary with situation and time. A child's behavior may be well-organized and appropriate on a one-to-one basis but become dysregulated in a group situation or in the classroom; or home adjustment may be satisfactory and difficulties may emerge only in school. It is the rare child who displays signs of the disorder in all settings or even in the same setting at all times.

Associated features. Associated features vary as a function of age and include obstinacy, stubbornness, negativism, bossiness, bullying, increased mood lability, low frustration tolerance, temper outbursts, low self-esteem, and lack of response to discipline.

Specific Developmental Disorders are common, and should be noted on Axis II.

Nonlocalized "soft" neurological signs, motor-perceptual dysfunctions (e.g., poor eye-hand coordination), and EEG abnormalities may be present. However, in only about 5% of the cases is Attention Deficit Disorder associated with a diagnosable neurological disorder, which should be coded on Axis III.

Age at onset. Onset is typically by the age of three, although frequently the disorder does not come to professional attention until the child enters school.

Course. There are three characteristic courses. In the first, all of the symptoms persist into adolescence or adult life. In the second, the disorder is self-limited and all of the symptoms disappear completely at puberty. In the third, the hyperactivity disappears, but the attentional difficulties and impulsivity persist into adolescence or adult life (Residual Type). The relative frequency of these courses is unknown.

Impairment. Academic difficulties are common; and although impairment may be limited to academic functioning, social functioning may be impaired as well. Infrequently children with this disorder require residential treatment.

Complications. School failure, Conduct Disorder, and Antisocial Personality Disorder are the major complications.

Predisposing factors. Mild or Moderate Mental Retardation, epilepsy, some forms of cerebral palsy, and other neurological disorders may be predisposing factors.

Prevalence. The disorder is common. In the United States, it may occur in as many as 3% of prepubertal children.

Sex ratio. The disorder is ten times more common in boys than in girls.

Familial pattern. The disorder is apparently more common in family members than in the general population.

Differential diagnosis. Age-appropriate overactivity, as is seen in some particularly active children, does not have the haphazard and poorly organized quality characteristic of the behavior of children with Attention Deficit Disorder. Children in **inadequate, disorganized,** or **chaotic environments** may appear to have difficulty in sustaining attention and in goal-directed behavior. In such cases it may be impossible to determine whether the disorganized behavior is simply a function of the chaotic environment or whether it is due to the child's psychopathology (in which case the diagnosis of Attention Deficit Disorder may be warranted).

In **Severe** and **Profound Mental Retardation** there may be clinical features that are characteristic of Attention Deficit Disorder. However, the additional diagnosis of Attention Deficit Disorder would make clinical sense only if the Mental Retardation were Mild or Moderate in severity.

Many cases of **Conduct Disorder** have signs of impulsivity, inattention, and hyperactivity. The additional diagnosis of Attention Deficit Disorder is frequently warranted.

In **Schizophrenia** and **Affective Disorders with manic features** there may be clinical features that are characteristic of Attention Deficit Disorder. However, these diagnoses preempt the diagnosis of Attention Deficit Disorder.

Diagnostic criteria for Attention Deficit Disorder with Hyperactivity

The child displays, for his or her mental and chronological age, signs of developmentally inappropriate inattention, impulsivity, and hyperactivity. The signs must be reported by adults in the child's environment, such as parents and teachers. Because the symptoms are typically variable, they may not be observed directly by the clinician. When the reports of teachers and parents conflict, primary consideration should be given to the teacher reports because of greater familiarity with age-appropriate norms. Symptoms typically worsen in situations that require self-application, as in the classroom. Signs of the disorder may be absent when the child is in a new or a one-to-one situation.

The number of symptoms specified is for children between the ages of eight and ten, the peak age range for referral. In younger children, more severe forms of the symptoms and a greater number of symptoms are usually present. The opposite is true of older children.

A. **Inattention.** At least three of the following:
   (1) often fails to finish things he or she starts
   (2) often doesn't seem to listen
   (3) easily distracted
   (4) has difficulty concentrating on schoolwork or other tasks requiring sustained attention

(5) has difficulty sticking to a play activity

B. **Impulsivity.** At least three of the following:

(1) often acts before thinking
(2) shifts excessively from one activity to another
(3) has difficulty organizing work (this not being due to cognitive impairment)
(4) needs a lot of supervision
(5) frequently calls out in class
(6) has difficulty awaiting turn in games or group situations

C. **Hyperactivity.** At least two of the following:

(1) runs about or climbs on things excessively
(2) has difficulty sitting still or fidgets excessively
(3) has difficulty staying seated
(4) moves about excessively during sleep
(5) is always "on the go" or acts as if "driven by a motor"

D. Onset before the age of seven.

E. Duration of at least six months.

F. Not due to Schizophrenia, Affective Disorder, or Severe or Profound Mental Retardation.

314.00 Attention Deficit Disorder without Hyperactivity

All of the features are the same as those of Attention Deficit Disorder with Hyperactivity except for the absence of hyperactivity; the associated features and impairment are generally milder. Prevalence and familial pattern are unknown.

Diagnostic criteria for Attention Deficit Disorder without Hyperactivity

The criteria for this disorder are the same as those for Attention Deficit Disorder with Hyperactivity except that the individual never had signs of hyperactivity (criterion C).

314.80 Attention Deficit Disorder, Residual Type

Diagnostic criteria for Attention Deficit Disorder, Residual Type

A. The individual once met the criteria for Attention Deficit Disorder with Hyperactivity. This information may come from the individual or from others, such as family members.

B. Signs of hyperactivity are no longer present, but other signs of the illness have persisted to the present without periods of remission, as evidenced by signs of both attentional deficits and impulsivity (e.g., difficulty organizing work and completing tasks, difficulty concentrating, being easily distracted, making sudden decisions without thought of the consequences).

C. The symptoms of inattention and impulsivity result in some impairment in social or occupational functioning.

D. Not due to Schizophrenia, Affective Disorder, Severe or Profound Mental Retardation, or Schizotypal or Borderline Personality Disorders.

CONDUCT DISORDER

The essential feature is a repetitive and persistent pattern of conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated. The conduct is more serious than the ordinary mischief and pranks of children and adolescents.

Four specific subtypes are included: Undersocialized, Aggressive; Undersocialized, Nonaggressive; Socialized, Aggressive; and Socialized, Nonaggressive. These subtypes are based on the presence or absence of adequate social bonds and the presence or absence of a pattern of aggressive antisocial behavior. The validity of these diagnostic subtypes within the category of Conduct Disorder is controversial. Some investigators believe that a more useful distinction would be on the basis of the variety, frequency, and seriousness of the antisocial behavior rather than the type of disturbance, whereas others believe that the Undersocialized and Socialized types represent distinct disorders.

The *Undersocialized* types are characterized by a failure to establish a normal degree of affection, empathy, or bond with others. Peer relationships are generally lacking, although the youngster may have superficial relationships with other youngsters. Characteristically the child does not extend himself or herself for others unless there is an obvious immediate advantage. Egocentrism is shown by readiness to manipulate others for favors without any effort to reciprocate. There is generally a lack of concern for the feelings, wishes, and well-being of others, as shown by callous behavior. Appropriate feelings of guilt or remorse are generally absent. Such a child may readily inform on his or her companions and try to place blame on them.

The *Socialized* types show evidence of social attachment to others, but may be similarly callous or manipulative toward persons to whom they are not attached and lack guilt when these "outsiders" are made to suffer.

The *Aggressive* types are characterized by a repetitive and persistent pattern of aggressive conduct in which the rights of others are violated, by either physical violence against persons, or thefts outside the home involving confrontation with a victim. The physical violence may take the form of rape, mugging, assault, or, in rare cases, homicide. In some cases, the physical violence may be

directed against parents. Thefts outside the home may involve extortion, purse-snatching, or holdup of a store.

The *Nonaggressive* types are characterized by the *absence* of physical violence against persons and of robbery outside the home involving confrontation with a victim. However, there is a persistent pattern of conduct in conflict with norms for their age, which may take the form of: chronic violations of a variety of important rules that are reasonable and age-appropriate for the child at home or at school, such as persistent truancy and substance abuse; running away from home overnight while living in the parental home; persistent serious lying in and out of the home; vandalism or fire-setting; or stealing (not involving confrontation of a victim).

Associated features (all four types). Difficulties at home and in the community are common. Frequently there is precocious sexual activity, which may be aggressive or submissive, depending on subtype. The child typically blames others for his or her difficulties and feels unfairly treated and mistrustful of others. Self-esteem is usually low, though the individual may project an image of "toughness." Unusually early smoking, drinking, and other substance use are also common. Poor frustration tolerance, irritability, temper outbursts, and provocative recklessness are often present. Academic achievement is frequently below the level expected on the basis of intelligence and age. Attentional difficulties are common, and may justify the additional diagnosis of Attention Deficit Disorder. One or more Specific Developmental Disorders may be present.

In the Socialized types, sometimes there is membership in a gang and the antisocial behavior may be limited to gang activities.

Age at onset. Onset is usually prepubertal for the Undersocialized type and pubertal or postpubertal for the Socialized type.

Course. The course is variable, mild forms frequently showing improvement over time and severe forms tending to be chronic. Some individuals may continue their antisocial behavior and generally poor social functioning into adulthood, particularly the Undersocialized, Aggressive type, and thus qualify for the diagnosis of Antisocial Personality Disorder. Others may display adequate social functioning but persist in illegal activity, and may be considered to have Adult Antisocial Behavior (V Code). Finally, many achieve reasonable social and occupational adjustment as adults, particularly the Socialized, Nonaggressive type.

Impairment. The degree of impairment varies from mild to severe. It may preclude attendance in the ordinary school classroom or living at home or in a foster home. When antisocial behavior is extreme, institutionalization, with its temporary loss of autonomy, may be necessary.

Complications. Complications include school suspension, legal difficulties, Substance Use Disorders, venereal diseases, unwanted pregnancy, high rate of

physical injury from accidents, fights, along with retaliation by victims, and suicidal behavior.

Predisposing factors. Attention Deficit Disorder, parental rejection, inconsistent management with harsh discipline, early institutional living, frequent shifting of parent figures (foster parents, relatives, or stepparents), and being an illegitimate only child may predispose to the development of the Undersocialized type. Large family size, association with a delinquent subgroup, and an absent father or a father with Alcohol Dependence may predispose to the development of the Socialized type.

Prevalence. The disorder is common, particularly the Socialized, Nonaggressive and the Undersocialized, Aggressive types.

Sex ratio. The disorder is far more common among boys than among girls, the ratios ranging from 4:1 to 12:1. The only exception may be the Undersocialized, Nonaggressive type, which may be equally common in both sexes.

Familial pattern. The disorder is more common in children of adults with Antisocial Personality Disorder and Alcohol Dependence than in the general population.

Differential diagnosis. Isolated acts of antisocial behavior do not justify a diagnosis of Conduct Disorder and may be coded as Childhood or Adolescent Antisocial Behavior (V Codes). The behavior qualifies for a diagnosis of Conduct Disorder only if the antisocial behavior represents a repetitive and persistent pattern. When such a pattern exists there will usually be obvious impairment in social and school functioning that frequently will not be present when the antisocial behavior represents an isolated act.

In **Oppositional Disorder** there are some of the features that are present in Conduct Disorder, such as disobedience and opposition to authority figures. However, the basic rights of others and major age-appropriate societal norms or rules are not violated as they are in Conduct Disorder.

Attention Deficit Disorder and **Specific Developmental Disorder** are common associated diagnoses, and should also be noted when present.

312.00 Conduct Disorder, Undersocialized, Aggressive

Diagnostic criteria

A. A repetitive and persistent pattern of aggressive conduct in which the basic rights of others are violated, as manifested by either of the following:

(1) physical violence against persons or property (not to defend someone else or oneself), e.g., vandalism, rape, breaking and entering, fire-setting, mugging, assault

(2) thefts outside the home involving confrontation with the victim (e.g., extortion, purse-snatching, armed robbery)

B. Failure to establish a normal degree of affection, empathy, or bond with others as evidenced by *no more than one* of the following indications of social attachment:

(1) has one or more peer-group friendships that have lasted over six months
(2) extends himself or herself for others even when no immediate advantage is likely
(3) apparently feels guilt or remorse when such a reaction is appropriate (not just when caught or in difficulty)
(4) avoids blaming or informing on companions
(5) shares concern for the welfare of friends or companions

C. Duration of pattern of aggressive conduct of at least six months.

D. If 18 or older, does not meet the criteria for Antisocial Personality Disorder.

312.10 Conduct Disorder, Undersocialized, Nonaggressive

Diagnostic criteria

A. A repetitive and persistent pattern of nonaggressive conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by any of the following:

(1) chronic violations of a variety of important rules (that are reasonable and age-appropriate for the child) at home or at school (e.g., persistent truancy, substance abuse)
(2) repeated running away from home overnight
(3) persistent serious lying in and out of the home
(4) stealing not involving confrontation with a victim

B. Failure to establish a normal degree of affection, empathy, or bond with others as evidenced by *no more than one* of the following indications of social attachment:

(1) has one or more peer-group friendships that have lasted over six months
(2) extends himself or herself for others even when no immediate advantage is likely
(3) apparently feels guilt or remorse when such a reaction is appropriate (not just when caught or in difficulty)
(4) avoids blaming or informing on companions
(5) shows concern for the welfare of friends or companions

C. Duration of pattern of nonaggressive conduct of at least six months.

D. If 18 or older, does not meet the criteria for Antisocial Personality Disorder.

312.23 Conduct Disorder, Socialized, Aggressive

Diagnostic criteria

A. A repetitive and persistent pattern of aggressive conduct in which the basic rights of others are violated, as manifested by either of the following:

(1) physical violence against persons or property (not to defend someone else or oneself), e.g., vandalism, rape, breaking and entering, fire-setting, mugging, assault
(2) thefts outside the home involving confrontation with a victim (e.g., extortion, purse-snatching, armed robbery)

B. Evidence of social attachment to others as indicated by at least two of the following behavior patterns:

(1) has one or more peer-group friendships that have lasted over six months
(2) extends himself or herself for others even when no immediate advantage is likely
(3) apparently feels guilt or remorse when such a reaction is appropriate (not just when caught or in difficulty)
(4) avoids blaming or informing on companions
(5) shows concern for the welfare of friends or companions

C. Duration of pattern of aggressive conduct of at least six months.

D. If 18 or older, does not meet the criteria for Antisocial Personality Disorder.

312.21 Conduct Disorder, Socialized, Nonaggressive

Diagnostic criteria

A. A repetitive and persistent pattern of nonaggressive conduct in which either the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by any of the following:

(1) chronic violations of a variety of important rules (that are reasonable and age-appropriate for the child) at home or at school (e.g., persistent truancy, substance abuse)
(2) repeated running away from home overnight
(3) persistent serious lying in and out of the home
(4) stealing not involving confrontation with a victim

B. Evidence of social attachment to others as indicated by at least two of the following behavior patterns:

(1) has one or more peer-group friendships that have lasted over six months
(2) extends himself or herself for others even when no immediate advantage is likely
(3) apparently feels guilt or remorse when such a reaction is appropriate (not just when caught or in difficulty)
(4) avoids blaming or informing on companions
(5) shows concern for the welfare of friends or companions

C. Duration of pattern of nonaggressive conduct of at least six months.

D. If 18 or older, does not meet the criteria for Antisocial Personality Disorder.

312.90 Atypical Conduct Disorder

This is a residual category for illnesses in which the predominant disturbance involves a pattern of conduct in which there is violation of either the basic rights of others or major age-appropriate societal norms or rules but which cannot be classified as one of the specified subtypes of Conduct Disorder.

ANXIETY DISORDERS OF CHILDHOOD OR ADOLESCENCE

This subclass includes three disorders in which anxiety is the predominant clinical feature. In the first two categories, Separation Anxiety Disorder and Avoidant Disorder of Childhood or Adolescence, the anxiety is focused on specific situations. In the third category, Overanxious Disorder, the anxiety is generalized to a variety of situations.

309.21 Separation Anxiety Disorder

The essential feature is a clinical picture in which the predominant disturbance is excessive anxiety on separation from major attachment figures or from home or other familiar surroundings. When separation occurs, the child may experience anxiety to the point of panic. The reaction is beyond that expected at the child's developmental level.

Children with Separation Anxiety Disorder are uncomfortable when they travel independently away from the house or from familiar areas. They may refuse to visit or sleep at friends' homes, to go on errands, or to attend camp or school.* They may be unable to stay in a room by themselves, and may display clinging behavior, staying close to the parent, "shadowing" the parent around the house. Physical complaints, such as stomachaches, headaches, nausea, and vomiting, are common when separation is anticipated or occurs.

* School refusal is often inaccurately referred to as "school phobia." However, not all school refusal is due to separation anxiety. When separation anxiety accounts for school refusal, the child experiences difficulty being separated from home or family for a variety of purposes, school attendance being only one of them. In a true school phobia, the child fears the school situation, whether or not he or she is accompanied by the parent.

Cardiovascular symptoms such as palpitations, dizziness, and faintness are rare in younger children, but may occur in adolescents.

When separated from significant others to whom they are attached, these children are often preoccupied with morbid fears that accidents or illness will befall their parents or themselves. They often express fear of getting lost and never being reunited with their parents. The exact nature of the fantasized mishaps varies. In general, young children have less specific, more amorphous concerns. As the child gets older, the fears may become systematized around identifiable potential dangers. Such concerns vary greatly; and many children, even some older ones, do not report fears of definite threats, but only pervasive anxiety about ill-defined dangers or death. In addition, children typically exhibit anticipatory anxiety when separation is threatened or impending. In young children, whose immature cognitive development precludes the formation of well-defined morbid worries, the mechanism of anticipatory anxiety has not yet developed, and there is distress only when separation actually occurs.

Children with this disorder often have fears of animals, monsters, and situations that are perceived as presenting danger to the integrity of the family or themselves; consequently, they may have exaggerated fears of muggers, burglars, kidnappers, car accidents, or plane travel. Concerns about dying are common.

These children often have difficulty going to sleep, and may require that someone stay with them until they fall asleep. They may make their way to their parents' bed (or that of another significant person, such as a sibling); if entry to the parental bedroom is barred, they may sleep outside the parents' door. Nightmares, whose content expresses the child's morbid fears, may occur.

Some children do not show morbid apprehension about possible harm befalling them or those close to them, but instead experience acute homesickness and feel uncomfortable to the point of misery and even panic when away from home. These children yearn to return home, and are preoccupied with reunion fantasies.

Children may refuse to see former friends or relatives to avoid accounting for their difficulties while in school or their absence from school. On occasion a child may become violent toward an individual who is forcing separation.

Adolescents with this disorder, especially boys, may deny overconcern about their mother or the wish to be with her; yet their behavior reflects anxiety about separation. Thus, they are reluctant or unable to leave the home or the parent and feel comfortable only in situations in which no separation is demanded.

Although the disorder represents a form of phobia, it is not included among the Phobic Disorders because it has unique features and is characteristically associated with childhood.

Associated features. Fear of the dark is common, and some children have fixed fears that may appear bizarre. For example, they may report that they see and feel eyes staring at them in the dark, that mythical animals are glaring at them, or that bloody creatures are reaching for them.

Children with this disorder are often described as demanding, intrusive, and in need of constant attention. Others are described as unusually conscientious, conforming, and eager to please.

When no demands for separation are made, children with Separation Anxiety Disorder typically have no interpersonal difficulties. They may complain that no one loves them or cares about them and that they wish they were dead.

Age at onset. The age at onset may be as early as preschool age. The extreme form of the disorder, involving school refusal, seems to begin most often around ages 11 and 12.

Course. Typically there are periods of exacerbation and remission over a period of several years. In some exceptional cases both the anxiety about possible separation and the avoidance of situations involving separation (e.g., going away to college) persist for many years.

Impairment. In its severe form the disorder may be very incapacitating in that the child is unable to attend school and function independently in a variety of areas.

Complications. The child often undergoes elaborate physical examinations because of numerous somatic complaints. When school refusal occurs, common complications are academic difficulties and social avoidance.

Predisposing factors. No specific premorbid personality disturbance is associated with Separation Anxiety Disorder. In most cases the disorder develops after some life stress, typically a loss, the death of a relative or pet, an illness of the child or a relative, or a change in the child's environment such as a school change or a move to a new neighborhood.

Children with this disorder tend to come from families that are close-knit and caring. The etiologic significance of this familial pattern is not clear. Neglected children are underrepresented among those with Separation Anxiety Disorders.

Prevalence. The disorder is apparently not uncommon.

Sex ratio. The disorder is apparently equally common in both sexes.

Familial pattern. The disorder is apparently more common in family members than in the general population.

Differential diagnosis. In early childhood some degree of separation anxiety is a normal phenomenon. Clinical judgment must be used to distinguish this from the clearly excessive reaction to separation seen in Separation Anxiety Disorder. In **Overanxious Disorder** and **Avoidant Disorder of Childhood or**

Adolescence anxiety is not focused on separation. In **Pervasive Developmental Disorder** or **Schizophrenia** anxiety about separation may occur, but is viewed as due to these conditions rather than as a separate disorder. In **Major Depression** occurring in children, the diagnosis Separation Anxiety Disorder should also be made when the criteria are met for both disorders, since it is difficult to know which condition should be regarded as the primary disorder. In **Conduct Disorder** truancy is common, but the child stays outside of the home and anxiety about separation is usually not present.

Diagnostic criteria for Separation Anxiety Disorder

A. Excessive anxiety concerning separation from those to whom the child is attached, as manifested by at least three of the following:

(1) unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return

(2) unrealistic worry that an untoward calamitous event will separate the child from a major attachment figure, e.g., the child will be lost, kidnapped, killed, or be the victim of an accident

(3) persistent reluctance or refusal to go to school in order to stay with major attachment figures or at home

(4) persistent reluctance or refusal to go to sleep without being next to a major attachment figure or to go to sleep away from home

(5) persistent avoidance of being alone in the home and emotional upset if unable to follow the major attachment figure around the home

(6) repeated nightmares involving theme of separation

(7) complaints of physical symptoms on school days, e.g., stomachaches, headaches, nausea, vomiting

(8) signs of excessive distress upon separation, or when anticipating separation, from major attachment figures, e.g., temper tantrums or crying, pleading with parents not to leave (for children below the age of six, the distress must be of panic proportions)

(9) social withdrawal, apathy, sadness, or difficulty concentrating on work or play when not with a major attachment figure

B. Duration of disturbance of at least two weeks.

C. Not due to a Pervasive Developmental Disorder, Schizophrenia, or any other psychotic disorder.

D. If 18 or older, does not meet the criteria for Agoraphobia.

313.21 Avoidant Disorder of Childhood or Adolescence

The essential feature is a clinical picture in which the predominant disturbance

is a persistent and excessive shrinking from contact with strangers of sufficient severity so as to interfere with social functioning in peer relationships, coupled with a clear desire for affection and acceptance, and relationships with family members and other familiar figures that are warm and satisfying.

Children with this disorder may cling and whisper to their caretakers, and become tearful and anxious when confronted with even trivial demands for contact with strangers. Social avoidance may be indicated by inhibition of motor action or initiative. Although there is no impairment in communicative skills, such children may seem inarticulate or even mute when social anxiety is severe. Embarrassment and timidity are conveyed by these children, although they seem interested and eager for social relationships.

Associated features. Usually such children are unassertive and lack self-confidence. In adolescence, inhibition of normal psychosexual activity may be noted.

Age at onset. The disorder may develop as early as two and a half years, after stranger anxiety as a normal developmental phenomenon should have disappeared.

Course. The course seems variable, some children improving spontaneously while others experience an episodic or chronic course. How often this disorder becomes chronic and continues into adulthood as Avoidant Personality Disorder is unknown. In general, however, it is believed that this rarely occurs.

Impairment. Age-appropriate socialization skills may not develop. It is rare for the impairment in functioning to be severe.

Predisposing factors. No information.

Complications. The most serious complication is failure to form social bonds beyond the family, with resulting feelings of isolation and depression.

Prevalence. The disorder is apparently uncommon.

Sex ratio and familial pattern. No information.

Differential diagnosis. Socially reticent children are slow to warm up to strangers, but after a short time can respond, and suffer no impairment in peer interaction.

In **Separation Anxiety Disorder**, the anxiety is due to separation from the home or major attachment figures rather than to contact with strangers per se. In **Overanxious Disorder,** anxiety is not limited to, or focused on, contact with strangers. In **Schizoid Disorder of Childhood or Adolescence** there is also discomfort in social situations, but there is little desire for social involvement, whereas in Avoidant Disorder of Childhood or Adolescence there is a clear desire for affection and acceptance. **Avoidant Personality Disorder,** rather than

Avoidant Disorder of Childhood or Adolescence, should be diagnosed only if the behavioral pattern has existed for many years and the individual is at least 18 years old. In **Adjustment Disorder with Withdrawal**, the behavioral pattern of withdrawal is clearly related to a recent psychosocial stressor.

Diagnostic criteria for Avoidant Disorder of Childhood or Adolescence

A. Persistent and excessive shrinking from contact with strangers.

B. Desire for affection and acceptance, and generally warm and satisfying relations with family members and other familiar figures.

C. Avoidant behavior sufficiently severe to interfere with social functioning in peer relationships.

D. Age at least 2½. If 18 or older, does not meet the criteria for Avoidant Personality Disorder.

E. Duration of the disturbance of at least six months.

313.00 Overanxious Disorder

The essential feature is a clinical picture in which the predominant disturbance is excessive worrying and fearful behavior that is not focused on a specific situation or object (such as separation from a parent or entering new social interaction) and that is not due to a recent psychosocial stressor. The child worries about future events, such as examinations, the possibility of injury, or inclusion in peer group activities; or about meeting expectations, such as deadlines, keeping appointments, or performing chores. An inordinate amount of time may be spent asking about the discomforts or dangers of a variety of situations. For example, routine visits to the doctor may be anticipated with excessive concern about minor procedures.

The anxiety is typically expressed as concern with competence in a variety of areas, with the focus of concern on what others will think of his or her performance. In some cases physical concomitants of anxiety are apparent, as manifested by complaints of a lump in the throat, gastrointestinal distress, headache, shortness of breath, nausea, dizziness, or other somatic discomforts. Difficulty falling asleep is common. The child may persistently complain about "feeling nervous."

There may be preoccupation with a neighbor or adult school figure who seems "mean" or critical. As the child gets older, the preoccupations usually systematize around conventional forms of judgment such as peer, social, or athletic acceptance, school grades, and even behavior of other family members that might embarrass the child.

Associated features. Children with this disorder may seem hypermature with their "precocious" concerns. Perfectionist tendencies, with obsessional self-

doubt, may be present; there may be excessive conformity and seeking of approval. Sometimes there is an excess of motor restlessness or nervous habits such as nail biting or hair pulling.

Course. The onset may be sudden or gradual, with exacerbations associated with stress. The disorder may persist into adult life, as an Anxiety Disorder, such as Generalized Anxiety Disorder or a Social Phobia.

Age at onset. No information.

Impairment. In unusually severe cases this disorder can be incapacitating and result in inability to meet realistic demands at home and in school.

Complications. Complications may include unnecessary medical evaluation for somatic symptoms, poor school performance, and failure to engage in age-appropriate activities in which there are demands for performance, such as sports.

Predisposing factors. This disorder seems more common in eldest children, small families, upper socioeconomic groups, and families in which there is a concern about performance even when the child functions at an adequate or superior level.

Prevalence. The disorder is apparently common.

Sex ratio. The disorder is apparently more common in boys than in girls.

Familial pattern. No information.

Differential diagnosis. In **Separation Anxiety Disorder**, the anxiety is focused on situations involving separation (e.g., going to school). Children with **Attention Deficit Disorder** may appear nervous and jittery, but are not unduly concerned about the future. The two disorders, however, may coexist. In **Adjustment Disorder with Anxious Mood**, the anxiety is always clearly related to the recent occurrence of a psychosocial stressor.

Overanxious Disorder should not be diagnosed when the anxiety is due to another disorder, such as **Obsessive Compulsive Disorder, Major Depression, Schizophrenia,** or **Pervasive Developmental Disorder.**

Diagnostic criteria for Overanxious Disorder

A. The predominant disturbance is generalized and persistent anxiety or worry (not related to concerns about separation), as manifested by at least four of the following:

(1) unrealistic worry about future events

(2) preoccupation with the appropriateness of the individual's behavior in the past

(3) overconcern about competence in a variety of areas, e.g., academic, athletic, social

(4) excessive need for reassurance about a variety of worries

(5) somatic complaints, such as headaches or stomachaches, for which no physical basis can be established

(6) marked self-consciousness or susceptibility to embarrassment or humiliation

(7) marked feelings of tension or inability to relax

B. The symptoms in A have persisted for at least six months.

C. If 18 or older, does not meet the criteria for Generalized Anxiety Disorder.

D. The disturbance is not due to another mental disorder, such as Separation Anxiety Disorder, Avoidant Disorder of Childhood or Adolescence, Phobic Disorder, Obsessive Compulsive Disorder, Depressive Disorder, Schizophrenia, or a Pervasive Developmental Disorder.

OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

313.89 Reactive Attachment Disorder of Infancy

The essential features of this disorder are signs of poor emotional development (lack of age-appropriate signs of social responsiveness, apathetic mood) and physical development (failure to thrive), with onset before eight months of age, because of lack of adequate caretaking. The disturbance is not due to a physical disorder, Mental Retardation, or Infantile Autism. Some severe cases of this disorder have also been called "failure to thrive" or "hospitalism."

Infants with this disorder present with poorly developed social responsivity. By two months of age visual tracking of eyes and faces may not be established; the smile response and gaze reciprocity may be absent. At four to five months the infant may fail to participate in playful, simple games with the caretaker or observer, to attempt vocal reciprocity, to reach out when he or she is to be picked up, to reach spontaneously for the mother, or to turn his or her head toward the side from which the voice of the caretaker or observer comes. At seven to eight months the infant may not yet be crawling, establishing visual or vocal communication with the caretaker, beginning to imitate the caretaker, or displaying any of the usual more subtle facial expressions of coyness, attentiveness, etc.

The child is apathetic; staring, weak cry, poor muscle tone, weak rooting and grasping reactions to attempts to feed, and low spontaneous motility are commonly observed. Excessive sleep and a rather generalized lack of interest in the environment are frequent manifestations of the disorder.

Often such infants are noticed by a pediatrician because of their failure to thrive. Since these infants frequently do not receive well-baby care, the reason for the visit to the pediatrician may be a complicating physical illness, usually infectious, or an associated feeding problem (e.g., rumination). The head circumference is generally normal, and the failure to gain weight is disproportionately greater than the failure (if any) to gain in length.

The diagnosis of Reactive Attachment Disorder of Infancy can be made only in the presence of clear evidence of lack of adequate care. This frequently requires either a home visit, observation of the interaction between the mother or surrogate parent and the infant during both feeding and nonfeeding periods, or reports from other observers. Maternal reports may not be reliable.

It is pathognomonic of this disorder that, except in cases of extreme neglect with consequent severe physical complications (e.g., starvation, dehydration, or other intercurrent physical complications that can cause death before therapeutic measures can take hold), the clinical picture can be completely reversed by adequate care. (Such care need not be provided by a single person to be effective; it can include hospitalization, for example.) Such a therapeutic response is ultimate confirmation of the diagnosis.

Associated features. Feeding disturbances may be present, in particular, rumination, regurgitations, and vomiting. Such disturbances may be related to psychosocial deprivation and may, in turn, be a central factor in malnutrition.

Child abuse is sometimes observed, but neglect is more common.

Age at onset. The diagnosis can be made as early as in the first month of life. Onset of the disorder is always before eight months, since attachments are formed by eight months if there has been adequate caretaking. A similar clinical picture with onset past the eighth month of age should be diagnosed as Major Depression if the appropriate criteria are met.

Course, impairment, and complications. If care remains grossly inadequate, severe malnutrition, intercurrent infection, and death can occur. As noted above, however, the disorder is reversible with appropriate treatment and does not recur if affectionate care is provided, preferably from a single primary caretaker. In the absence of severe physical complications and with the proper treatment, psychological complications are likely to be limited to the effects that long-term institutionalization, if a factor in a particular case, may have on personality development.

Predisposing factors. All factors that interfere with early emotional "bonding" can predispose to this disorder.

With regard to the caretaker, these include: severe depression, maternal isolation and lack of support systems, obsessions of infanticide that make the mother stay away from the infant, maternal neglect and indifference toward the infant, extreme deprivation during the mother's own childhood, and lack of opportunities to learn about maternal behavior.

Babies that are "difficult" or very lethargic may frustrate the caretaker

excessively and enhance chances of the disorder's developing; but the role of such factors is not entirely clear.

Other factors that predispose to the disorder are lack of body-to-body contact during the first weeks of life, such as a prolonged period in an incubator or other early separations from a caring adult.

The relative contribution of psychosocial deprivation and simple food deprivation to the development of this disorder is unknown, but it is likely that both factors play a part in the majority of cases.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. Children with **Mental Retardation** develop slowly, but show no medically unexplainable failure to thrive unless Reactive Attachment Disorder of Infancy is also present. Children with **Infantile Autism** may display lack of attachment behavior as infants, but they usually show no failure to thrive, and there is generally no evidence of lack of caretaking. However, Infantile Autism and Reactive Attachment Disorder of Infancy can coexist.

Children with a variety of **severe neurological abnormalities** such as **deafness, blindness, profound multisensory defects, major CNS disease,** or **severe chronic physical illness** may have very specific needs and few means of satisfying them and thus may suffer minor secondary attachment disturbances.

In **psychosocial dwarfism** there may also be apathy, parental neglect, and disappearance of symptoms with hospitalization. However, psychosocial dwarfism generally has a later onset than Reactive Attachment Disorder of Infancy, and the failure of the infant to gain in length with little change or actual increase in weight is the major manifestation.

Major Depression should be considered if this clinical picture develops after eight months of age.

Diagnostic criteria for Reactive Attachment Disorder of Infancy

A. Age at onset before eight months.

B. Lack of the type of care that ordinarily leads to the development of affectional bonds to others, e.g., gross emotional neglect, imposed social isolation in an institution.

C. Lack of developmentally appropriate signs of social responsivity, as indicated by at least several of the following (the total number of behaviors looked for will depend on the chronological age of the child, corrected for prematurity):

(1) lack of visual tracking of eyes and faces by an infant more than two months of age
(2) lack of smiling in response to faces by an infant more than two months of age

(3) lack of visual reciprocity in an infant of more than two months; lack of vocal reciprocity with caretaker in an infant of more than five months
(4) lack of alerting and turning toward caretaker's voice by an infant of more than four months
(5) lack of spontaneous reaching for the mother by an infant of more than four months
(6) lack of anticipatory reaching when approached to be picked up, by an infant more than five months of age
(7) lack of participation in playful games with caretaker by an infant of more than five months

D. At least three of the following:

(1) weak cry
(2) excessive sleep
(3) lack of interest in the environment
(4) hypomotility
(5) poor muscle tone
(6) weak rooting and grasping in response to feeding attempts

E. Weight loss or failure to gain appropriate amount of weight for age unexplainable by any physical disorder. In these cases usually the failure to gain weight (falling weight percentile) is disproportionately greater than failure to gain length; head circumference is normal.

F. Not due to a physical disorder, Mental Retardation, or Infantile Autism.

G. The diagnosis is confirmed if the clinical picture is reversed shortly after institution of adequate caretaking, which frequently includes short-term hospitalization.

313.22 Schizoid Disorder of Childhood or Adolescence

The essential feature is a defect in the capacity to form social relationships that is not due to any other mental disorder, such as Pervasive Developmental Disorder; Conduct Disorder, Undersocialized, Nonaggressive; or any psychotic disorder, such as Schizophrenia.

Children with this disorder have no close friend of similar age other than a relative or a similarly socially isolated child. They do not appear distressed by their isolation, show little desire for social involvement, and prefer to be "loners," although they may be attached to a parent or other adult. When placed in social situations, they are uncomfortable, inept, and awkward. They have no interest in activities that involve other children, such as team sports and clubs. They often appear aloof, reserved, withdrawn, and seclusive.

Associated features. These children may be belligerent and irritable, especially when demands for social performance are made. They are erratically

sensitive to criticism, displaying occasional outbursts of aggressive behavior. They are frequently scapegoated by their peers.

These children often are vague about their goals, indecisive, absentminded, and detached from their environment ("not with it" or "in a fog"). They often appear self-absorbed and engage in excessive daydreaming. They tend to pursue solitary interests and hobbies and are often preoccupied with esoteric topics, such as violence or supernatural phenomena. However, they show no loss of reality testing.

Age at onset. The disorder always begins in childhood and can be differentiated from normal social reticence as early as five years of age.

Course. The course is not well known. In some there may be increased withdrawal and detachment in adolescence and continuity with adult Schizoid Personality Disorder or Schizophrenia. In others the disorder is self-limited, with increased socialization during adolescence.

Impairment. Social relations are, by definition, severely restricted, with failure to learn the social skills necessary for adequate social functioning. Academic performance is often impaired.

Complications. Schizoid Personality Disorder and Schizophrenia may develop as complications of this disorder.

Prevalence. This disorder is apparently rare.

Sex ratio. The disorder is much more common in boys than in girls.

Predisposing factors and familial pattern. No information.

Differential diagnosis. Children with **Avoidant Disorder of Childhood or Adolescence** are interested in social participation, but are inhibited by anxiety from forming social contacts. Peer interaction, once established, is enjoyed. In **Schizophrenia** and **Pervasive Developmental Disorders** there are psychotic symptoms or marked defects in multiple areas of functioning. In **Conduct Disorder, Undersocialized, Nonaggressive** the predominant disturbance is antisocial behavior.

Diagnostic criteria for Schizoid Disorder of Childhood or Adolescence

A. No close friend of similar age other than a relative or a similarly socially isolated child.

B. No apparent interest in making friends.

C. No pleasure from usual peer interactions.

D. General avoidance of nonfamilial social contacts, especially with peers.

E. No interest in activities that involve other children (such as team sports, clubs).

F. Duration of the disturbance of at least three months.

G. Not due to Pervasive Developmental Disorder; Conduct Disorder, Undersocialized, Nonaggressive; or any psychotic disorder, such as Schizophrenia.

H. If 18 or older, does not meet the criteria for Schizoid Personality Disorder.

313.23 Elective Mutism

The essential feature is continuous refusal to speak in almost all social situations, including at school, despite ability to comprehend spoken language and to speak. These children may communicate via gestures, by nodding or shaking the head, or, in some cases, by monosyllabic or short, monotone utterances.

Children with this disorder generally have normal language skills, though some have delayed language development and abnormalities of articulation. The refusal to speak is not, however, due to a language insufficiency or another mental disorder.

Associated features. Excessive shyness, social isolation and withdrawal, clinging, school refusal, Functional Encopresis, Functional Enuresis, compulsive traits, negativism, temper tantrums, or other controlling or oppositional behavior, particularly in the home, may be observed.

Age at onset. Although onset is usually before age five, the disturbance may come to clinical attention only with entry into school.

Course. In most cases the disturbance lasts only a few weeks or months, although in a few it continues for several years.

Impairment. There may be severe impairment in social and school functioning.

Complications. School failure and teasing or scapegoating by peers are common complications.

Predisposing factors. Maternal overprotection, speech disorders, Mental Retardation, immigration, hospitalization or trauma before age three, and entering school may be predisposing factors.

Prevalence. The disorder is apparently rare: it is found in less than 1% of child-guidance, clinical, and school-social-casework referrals.

Sex ratio. The disorder is slightly more common in girls than in boys.

Familial pattern. No information.

Differential diagnosis. In **Severe** or **Profound Mental Retardation, Pervasive Developmental Disorder,** or **Developmental Language Disorder,** there may be general inability to speak. In **Major Depression, Avoidant Disorder of Childhood or Adolescence, Overanxious Disorder, Oppositional Disorder,** and **Social Phobia,** there may be a general refusal to speak. However, in none of these disorders is the lack of speaking the predominant disturbance.

Children in families who have emigrated to a country of a different language may refuse to speak the new language. When comprehension of the new language is adequate but the refusal to speak persists, Elective Mutism should be diagnosed.

Diagnostic criteria for Elective Mutism

A. Continuous refusal to talk in almost all social situations, including at school.

B. Ability to comprehend spoken language and to speak.

C. Not due to another mental or physical disorder.

313.81 Oppositional Disorder

The essential feature is a pattern of disobedient, negativistic, and provocative opposition to authority figures. The diagnosis is not made if there is a pattern in which the basic rights of others or major age-appropriate societal norms or rules are violated, in which case the diagnosis of Conduct Disorder is made, or if the disturbance is due to another mental disorder, such as Schizophrenia or Pervasive Developmental Disorder. If the individual is 18 years or older, the disturbance does not meet the criteria for Passive-Aggressive Personality Disorder.

The oppositional attitude is toward family members, particularly the parents, and toward teachers. The most striking feature is the persistence of the oppositional attitude even when it is destructive to the interests and well-being of the child or adolescent. For example, if there is a rule, it is usually violated; if a suggestion is made, the individual is against it; if asked to do something, the individual refuses or becomes argumentative; if asked to refrain from an act, the child or adolescent feels obliged to carry it out. The behavior may, in fact, deprive the individual of productive activity and pleasurable relationships.

The continually confronting quality of these individuals is typical of their style and relationships. At times they may appear to be conforming, but in their conformity they still remain provocative toward those around them. Their provocation is often directed toward adults, but may well include other children.

If the individual is thwarted, temper tantrums are likely. These children or adolescents use negativism, stubbornness, dawdling, procrastination, and passive resistance to external authority.

Usually the individual does not regard himself or herself as "oppositional," but sees the problem as arising from other people, who are making unreasonable demands. The disorder generally causes more distress to those around him or her than to the person himself or herself.

Associated features. School and family difficulties are common. There may be use of illegal substances, such as cannabis and alcohol (before the legal age).

Age at onset. The disorder may begin as early as three years, but more commonly begins in late childhood or adolescence.

Course. The course is usually chronic and lasts for several years. In some cases there may be continuity with adult Passive-Aggressive Personality Disorder.

Impairment. The disorder can interfere with all social relationships. It may cause serious academic problems if it includes refusal to learn.

Complications. School failure is a common complication.

Predisposing factors, prevalence, sex ratio, familial pattern. No information.

Differential diagnosis. Oppositional behavior in 18-to-36-month-old children is part of a normal developmental phase. The diagnosis of Oppositional Disorder should be considered only if severe oppositional behavior persists beyond this period.

In **Conduct Disorder** there is violation of either the basic rights of others or major age-appropriate societal norms and rules, whereas in Oppositional Disorder the disturbance is never so severe and therefore does not extend to persistent lying, violation of major rules (e.g., truancy), theft, physical aggression, or vandalism. In some instances what first appears to be Oppositional Disorder may later turn out to be an early manifestation of Conduct Disorder.

In **Schizophrenia** and **Pervasive Developmental Disorders** there may be persistent oppositional behavior. However, if the oppositional behavior is due to these disorders, the diagnosis of Oppositional Disorder is not made.

Some cases of **Attention Deficit Disorder, Mental Retardation,** or **chronic Organic Mental Disorders** may also meet the criteria for this disorder, in which case both diagnoses should be made.

Diagnostic criteria for Oppositional Disorder

A. Onset after 3 years of age and before age 18.

B. A pattern, for at least six months, of disobedient, negativistic, and provocative opposition to authority figures, as manifested by at least two of the following symptoms:

(1) violations of minor rules
(2) temper tantrums
(3) argumentativeness
(4) provocative behavior
(5) stubbornness

C. No violation of the basic rights of others or of major age-appropriate societal norms or rules (as in Conduct Disorder); and the disturbance is not due to another mental disorder, such as Schizophrenia or a Pervasive Developmental Disorder.

D. If 18 or older, does not meet the criteria for Passive-Aggressive Personality Disorder.

313.82 Identity Disorder

The essential feature is severe subjective distress regarding inability to reconcile aspects of the self into a relatively coherent and acceptable sense of self. There is uncertainty about a variety of issues relating to identity, including long-term goals, career choice, friendship patterns, sexual orientation and behavior, religious identification, moral values, and group loyalties. These symptoms last at least three months and result in impairment in social or occupational (including academic) functioning. The disturbance is not due to another mental disorder, such as Affective Disorder, Schizophrenia, or Schizophreniform Disorder; and if the individual is 18 years or older, the disturbance does not meet the criteria for Borderline Personality Disorder.

The uncertainty regarding long-term goals may be expressed as inability to choose or adopt a life pattern, for example, one dedicated to material success, or service to the community, or even some combination of the two. Conflict regarding career choice may be expressed as inability to decide on a career or as inability to pursue an apparently chosen field. Conflict regarding friendship patterns may be manifested as inability to decide the kinds of people with whom to be friendly and the degree of intimacy to have. Conflict regarding values and loyalties may include concerns over religious identification, patterns of sexual behavior, and moral issues. The individual experiences these conflicts as irreconcilable aspects of his or her personality and, as a result, fails to perceive himself or herself as having a coherent identity. Frequently, the disturbance is epitomized by the individual's asking the question "Who am I?"

Associated features. Mild anxiety and depression are common and are usually related to inner preoccupation rather than external events. Self-doubt and doubt about the future are usually present, with either difficulty in making choices or impulsive experimentation. Negative or oppositional patterns are often

chosen in an attempt to establish an independent identity distinct from family or other close individuals. Such attempts may be manifested as transient experimental phases of widely divergent behavior as the individual "tries on" various roles.

Age at onset and course. The most common age at onset is late adolescence, when individuals generally become detached from their family value systems and attempt to establish independent identities. (This diagnosis appears in this section of the manual because the most common onset is in adolescence.) As value systems change, this disorder may also appear in young adulthood, or even in middle age, if an individual begins to question earlier life decisions.

Frequently there is a phase with acute onset, which either resolves over a period of time or becomes chronic. In other instances the onset is more gradual. If the disorder begins in adolescence, it usually is resolved by the mid-20s. If it becomes chronic, however, the individual may be unable to establish a career commitment or may fail to form lasting emotional attachments, with resulting frequent shifts in jobs, relationships, and career directions.

Impairment. The degree of impairment varies. Usually there is some interference in occupational and social functioning, with deterioration in friendships and family relationships.

Complications. Educational achievement and work performance below that appropriate to the individual's intellectual ability may result from this disorder.

Prevalence. No information. The disorder is apparently more common now than several decades ago, however, perhaps because today there are more options regarding values, behavior, and life-styles open to the individual and more conflict between adolescent peer values and parental or societal values.

Predisposing factors, sex ratio, and familial pattern. No information.

Differential diagnosis. Normal conflicts associated with maturing, such as "adolescent turmoil" or "middle-age crisis," are usually not associated with severe distress and impairment in occupational or social functioning. Nevertheless, if the criteria are met, the diagnosis of Identity Disorder should be given regardless of the developmental stage of the individual.

In **Schizophrenia, Schizophreniform Disorder,** and **Affective Disorder** there frequently are marked disturbances in identity, but these diagnoses preempt the diagnosis of Identity Disorder.

In **Borderline Personality Disorder** identity disturbances are only one of several important areas of disturbance, and there is often considerable mood disturbance. If the individual is 18 or over and meets the criteria for Borderline Personality Disorder, then that diagnosis preempts the diagnosis of Identity Disorder. What appears initially to be Identity Disorder may later turn out to have been an early manifestation of one of the disorders noted above.

Diagnostic criteria for Identity Disorder

A. Severe subjective distress regarding uncertainty about a variety of issues relating to identity, including three or more of the following:

(1) long-term goals
(2) career choice
(3) friendship patterns
(4) sexual orientation and behavior
(5) religious identification
(6) moral value systems
(7) group loyalties

B. Impairment in social or occupational (including academic) functioning as a result of the symptoms in A.

C. Duration of the disturbance of at least three months.

D. Not due to another mental disorder, such as Affective Disorder, Schizophrenia, or Schizophreniform Disorder.

E. If 18 or older, does not meet the criteria for Borderline Personality Disorder.

EATING DISORDERS

This subclass of disorders is characterized by gross disturbances in eating behavior; it includes Anorexia Nervosa, Bulimia, Pica, Rumination Disorder of Infancy, and Atypical Eating Disorder. Bulimia usually has a chronic, remitting course, whereas the other three specific disorders commonly are limited to a single episode. Two of these, Anorexia Nervosa and Rumination Disorder of Infancy, may have an unremitting course that progresses to death.

Simple obesity is included in ICD-9-CM as a physical disorder and is not in this section since it is not generally associated with any distinct psychological or behavioral syndrome. However, when there is evidence that psychological factors are of importance in the etiology or course of a particular case of obesity, this can be indicated by noting Psychological Factors Affecting Physical Condition (p. 303).

307.10 Anorexia Nervosa

The essential features are intense fear of becoming obese, disturbance of body image, significant weight loss, refusal to maintain a minimal normal body weight, and amenorrhea (in females). The disturbance cannot be accounted for by a known physical disorder. (The term "anorexia" is a misnomer, since loss of appetite is usually rare until late in the illness.)

Individuals with this disorder say they "feel fat" when they are of normal weight or even emaciated. They are preoccupied with their body size and often

gaze at themselves in a mirror. At least 25% of their original body weight is lost, and a minimal normal weight for age and height is not maintained.

The weight loss is usually accomplished by a reduction in total food intake, with a disproportionate decrease in high carbohydrate- and fat-containing foods, self-induced vomiting, use of laxatives or diuretics, and extensive exercising.

The individual usually comes to medical attention when weight loss becomes significant. When it becomes profound, physical signs such as hypothermia, dependent edema, bradycardia, hypotension, lanugo (neonatal-like hair), and a variety of metabolic changes occur. Amenorrhea often appears before noticeable weight loss has occurred.

Associated features. Some individuals with this disorder cannot exert continuous control over their intended voluntary restriction of food intake and have bulimic episodes (eating binges), often followed by vomiting. Other peculiar behavior concerning food is common. For example, individuals with this disorder often prepare elaborate meals for others, but tend to limit themselves to a narrow selection of low-calorie foods. In addition, food may be hoarded, concealed, crumbled, or thrown away.

Most individuals with this disorder steadfastly deny the illness and are uninterested in, even resistant to, therapy. Many of the adolescents have delayed psychosexual development, and adults have a markedly decreased interest in sex. Compulsive behavior, such as hand-washing, may be present during the illness. A higher than expected frequency of urogenital abnormalities and Turner's syndrome has been found in individuals with Anorexia Nervosa.

Age at onset. Age at onset is usually early to late adolescence, although it can range from prepuberty to the early 30s (rare).

Sex ratio and prevalence. This disorder occurs predominantly in females (95%). As many as 1 in 250 females between 12 and 18 years (high-risk age group) may develop the disorder.

Course. The course may be unremitting until death by starvation, episodic, or, most commonly, a single episode with full recovery.

Impairment. The severe weight loss often necessitates hospitalization to prevent death by starvation.

Complications. Follow-up studies indicate mortality rates between 15% and 21%.

Familial pattern. The disorder is more common among sisters and mothers of individuals with the disorder than in the general population.

Predisposing factors. In some individuals the onset of illness is associated with a stressful life situation. Many of these individuals are described as having

been overly perfectionist "model children." About one-third of the individuals are mildly overweight before the onset of the illness.

Differential diagnosis. In **Depressive Disorders,** and **certain physical disorders,** weight loss can occur, but there is no intense fear of obesity or disturbance of body image.

In **Schizophrenia** there may be bizarre eating patterns; however, the full syndrome of Anorexia Nervosa is rarely present; when it is, both diagnoses should be given.

In **Bulimia,** weight loss, if it does occur, is never as great as 25% of original body weight. In rare instances an episode of Anorexia Nervosa occurs in an individual with Bulimia, in which case both diagnoses are given.

Diagnostic criteria for Anorexia Nervosa

A. Intense fear of becoming obese, which does not diminish as weight loss progresses.

B. Disturbance of body image, e.g., claiming to "feel fat" even when emaciated.

C. Weight loss of at least 25% of original body weight or, if under 18 years of age, weight loss from original body weight plus projected weight gain expected from growth charts may be combined to make the 25%.

D. Refusal to maintain body weight over a minimal normal weight for age and height.

E. No known physical illness that would account for the weight loss.

307.51 Bulimia

The essential features are episodic binge eating accompanied by an awareness that the eating pattern is abnormal, fear of not being able to stop eating voluntarily, and depressed mood and self-deprecating thoughts following the eating binges. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

Eating binges may be planned. The food consumed during a binge often has a high caloric content, a sweet taste, and a texture that facilitates rapid eating. The food is usually eaten as inconspicuously as possible, or secretly. The food is usually gobbled down quite rapidly, with little chewing. Once eating has begun, additional food may be sought to continue the binge, and often there is a feeling of loss of control or inability to stop eating. A binge is usually terminated by abdominal pain, sleep, social interruption, or induced vomiting. Vomiting decreases the physical pain of abdominal distention, allowing either continued eating or termination of the binge, and often reduces post-binge anguish.

Although eating binges may be pleasurable, disparaging self-criticism and a depressed mood follow.

Individuals with Bulimia usually exhibit great concern about their weight and make repeated attempts to control it by dieting, vomiting, or the use of cathartics or diuretics. Frequent weight fluctuations due to alternating binges and fasts are common. Often these individuals feel that their life is dominated by conflicts about eating.

Associated features. Although most individuals with Bulimia are within a normal weight range, some may be slightly underweight and others may be overweight. Some individuals are subject to intermittent Substance Abuse, most frequently of barbiturates, amphetamines, or alcohol. Individuals may manifest undue concern with body image and appearance, often related to sexual attractiveness, with a focus on how others will see and react to them.

Age at onset. The disorder usually begins in adolescence or early adult life.

Sex ratio. The disorder occurs predominantly in females.

Course. The usual course is chronic and intermittent over a period of many years. Usually the binges alternate with periods of normal eating, or with periods of normal eating and fasts. In extreme cases, however, there may be alternate binges and fasts with no periods of normal eating.

Familial pattern. No information, although frequently obesity is present in parents or siblings.

Impairment and complications. Bulimia is seldom incapacitating except in a few individuals who spend their entire day in binge eating and self-induced vomiting. Electrolyte imbalance and dehydration can occur in those below normal weight who vomit after binges.

Prevalence and predisposing factors. No information.

Differential diagnosis. In **Anorexia Nervosa** there is severe weight loss, but in Bulimia the weight fluctuations are never so extreme as to be life-threatening. In **Schizophrenia** there may be unusual eating behavior, but the full syndrome of Bulimia is rarely present; when it is, both diagnoses should be given. In **certain neurological diseases,** such as **epileptic equivalent seizures, CNS tumors, Klüver-Bucy-like syndromes,** and **Klein-Levin syndrome,** there are abnormal eating patterns, but the diagnosis Bulimia is rarely warranted; when it is, both diagnoses should be given.

Diagnostic criteria for Bulimia

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:

(1) consumption of high-caloric, easily ingested food during a binge
(2) inconspicuous eating during a binge
(3) termination of such eating episodes by abdominal pain, sleep, social interruption, or self-induced vomiting
(4) repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
(5) frequent weight fluctuations greater than ten pounds due to alternating binges and fasts

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily.

D. Depressed mood and self-deprecating thoughts following eating binges.

E. The bulimic episodes are not due to Anorexia Nervosa or any known physical disorder.

307.52 Pica

The essential feature is the persistent eating of a nonnutritive substance. Infants with the disorder typically eat paint, plaster, string, hair, or cloth. Older children may eat animal droppings, sand, bugs, leaves, or pebbles. There is no aversion to food.

Associated features. There are no regularly associated features.

Age at onset. Age at onset is usually from 12 to 24 months, but may be earlier.

Course. Pica usually remits in early childhood, but may persist into adolescence or, rarely, continue through adulthood.

Impairment. None.

Complications. Lead poisoning may result from the ingestion of paint or paint-soaked plaster; hairball tumors may cause intestinal obstruction.

Predisposing factors. Mental Retardation, mineral deficiency (e.g., of zinc or iron), neglect, and poor supervision may be predisposing factors.

Prevalence and sex ratio. Pica is a rare disorder, and is reported equally for both sexes.

Familial pattern. No information.

Differential diagnosis. In **Infantile Autism, Schizophrenia,** and **certain physical disorders,** such as **Klein-Levin syndrome,** nonnutritive substances may be eaten. In such instances Pica should not be noted as an additional diagnosis.

Diagnostic criteria for Pica

A. Repeated eating of a nonnutritive substance for at least one month.

B. Not due to another mental disorder, such as Infantile Autism or Schizophrenia, or a physical disorder, such as Klein-Levin Syndrome.

307.53 Rumination Disorder of Infancy

The essential feature is repeated regurgitation of food, with weight loss or failure to gain expected weight, developing after a period of normal functioning. Partially digested food is brought up into the mouth without nausea, retching, disgust, or associated gastrointestinal disorder. The food is then ejected from the mouth or chewed and reswallowed. A characteristic position of straining and arching the back with the head held back is observed. Sucking movements of the tongue occur, and the infant gives the impression of gaining considerable satisfaction from the activity.

Associated features. Commonly there are irritability and hunger between episodes of regurgitation.

Age at onset. The disorder usually starts between 3 and 12 months of age. In children with Mental Retardation, it occasionally begins later.

Course. The disorder is potentially fatal. A mortality rate from malnutrition as high as 25% has been reported. In severe cases, although the infant is apparently hungry and ingests large amounts of food, progressive malnutrition occurs because regurgitation immediately follows the feedings. Spontaneous remissions are thought to be common.

Impairment. If failure to gain expected weight or severe malnutrition develops, developmental delays in all spheres often occur, and impairment can be severe.

Complications. A frequent complication of this disorder is that the caretaker becomes discouraged by failure to feed the infant successfully, and becomes alienated from the child. The noxious odor of the regurgitated material also leads to avoidance of the infant by the caretaker, with resulting understimulation.

Predisposing factors and familial pattern. No information.

Prevalence. The disorder is apparently very rare.

Sex ratio. The disorder is equally common in boys and in girls.

Differential diagnosis. Congenital anomalies, such as **pyloric stenosis, or infections of the gastrointestinal system,** can cause regurgitation of food and need to be ruled out by appropriate physical examination.

Diagnostic criteria for Rumination Disorder of Infancy

A. Repeated regurgitation without nausea or associated gastrointestinal illness for at least one month following a period of normal functioning.

B. Weight loss or failure to make expected weight gain.

307.50 Atypical Eating Disorder

This category is a residual category for eating disorders that cannot be adequately classified in any of the previous categories.

STEREOTYPED MOVEMENT DISORDERS

The essential feature of disorders in this subclass is an abnormality of gross motor movement. The specific Stereotyped Movement Disorders all involve tics and include Transient Tic Disorder, Chronic Motor Tic Disorder, and Tourette's Disorder. It is unknown whether the three tic disorders represent distinct conditions or a continuum of severity.

Differential diagnosis of tics. A tic is defined as an involuntary rapid movement of a functionally related group of skeletal muscles or the involuntary production of noises or words. Tics should be distinguished from other movement disturbances. *Choreiform movements* are dancing, random, irregular, nonrepetitive movements. *Dystonic movements* are slower, twisting movements interspersed with prolonged states of muscular tension. *Athetoid movements* are slow, irregular, writhing movements, most frequently in the fingers and toes. *Myoclonic movements* are brief, shocklike muscle contractions that may affect parts of or a whole muscle, but not entire muscle groups. *Hemiballismic movements* are intermittent, coarse, jumping, and unilateral movements of the limbs. *Spasms* are stereotypic, slower, and more prolonged than tics, and involve groups of muscles. *Hemifacial spasm* consists of irregular, repetitive, unilateral jerks of facial muscles. *Synkinesis* consists of movements of the corner of the mouth when the individual intends to close the eye, and its converse. *Dyskinesias,* such as tardive dyskinesia, are silent, oral-buccal-lingual, masticatory movements in the face and choreoathetoid movements in the limbs. The term "stereotyped movement," which is here used as a diagnostic term, refers to a voluntary, brief or prolonged habit or mannerism that often is experienced as pleasurable. (See Atypical Stereotyped Movement Disorder, p. 77.)

Associated features of Tic Disorders. Shame and self-consciousness are common, especially with Tourette's Disorder.

Impairment in Tic Disorders. Social and occupational functioning may be impaired owing to social ostracism or the interference in normal functioning caused by the tics.

307.21 Transient Tic Disorder

The essential features are recurrent involuntary, repetitive, rapid movements (tics). The movements can be voluntarily suppressed for minutes to hours. The intensity of the symptoms varies over weeks or months. The onset is during childhood or adolescence. The duration is at least one month, but not more than one year.

The most common tic is an eye blink or another facial tic. However, the whole head, torso, or limbs may be involved. In addition, there may be vocal tics. An individual may have only one or a number of tics; if the latter, the tics may be performed simultaneously, sequentially, or randomly.

Tics are exacerbated by stress or anticipation. They disappear during sleep, and may become attenuated during some absorbing activities. The individual may be successful in temporarily suppressing the tics; eventually, however, the tics reappear. From week to week or month to month, the strength and frequency of the tics will change.

Age at onset. The age at onset is always during childhood or early adolescence, and may be as early as two years of age.

Course. The tics may disappear permanently, or recur, especially during periods of stress. In rare cases, after a period of partial remission, the individual may develop Tourette's Disorder.

Complications and predisposing factors. No information.

Prevalence. Surveys of schoolchildren have reported that from 12% to 24% of the children have had a history of some kind of tic. However, since these surveys do not specify a minimum or a maximum duration, it is not known how applicable these findings are to the prevalence of Tic Disorders as defined in this manual.

Sex ratio. Most studies find the disorder three times as common in boys as in girls.

Familial pattern. Tics are apparently more common in family members than in the general population.

Differential diagnosis. In **Tourette's Disorder** and **Chronic Motor Tic Disorder** the duration of the disturbance is at least one year. In Tourette's Disorder there are vocal tics which are rarely present in Transient Tic Disorder. See differential diagnosis of tics (p. 73) and Tourette's Disorder (p. 77).

Diagnostic criteria for Transient Tic Disorder

A. Onset during childhood or early adolescence.

B. Presence of recurrent, involuntary, repetitive, rapid, purposeless, motor movements (tics).

C. Ability to suppress the movements voluntarily for minutes to hours.

D. Variation in the intensity of the symptoms over weeks or months.

E. Duration of at least one month but not more than one year.

307.22 Chronic Motor Tic Disorder

The essential features are recurrent, involuntary, repetitive, rapid movements (tics), usually involving no more than three muscle groups at any one time. The movements can be voluntarily suppressed for minutes to hours. The intensity of the symptoms is constant over weeks or months, and the duration is at least one year. Vocal tics occur infrequently. When present, they are not loud, intense or noticeable; frequently they are grunts or other noises caused by thoracic, abdominal, or diaphragmatic contractions.

Age at onset. The age at onset appears to be either in childhood or after age 40. When the onset is in adult life, the tic tends to be limited to a single muscle group.

Course. The course tends to be chronic.

Complications, predisposing factors, sex ratio, familial pattern and prevalence. No information.

Differential diagnosis. In **Transient Tic Disorder** the tics vary in intensity over time and the duration of the disturbance is always less than one year. In **Tourette's Disorder** the intensity of the tics varies over time, vocal tics are prominent and the motor movements are weaker and of briefer duration. See differential diagnosis of tics (p. 73) and Tourette's Disorder (p. 77).

Diagnostic criteria for Chronic Motor Tic Disorder

A. Presence of recurrent, involuntary, repetitive, rapid, purposeless movements (tics) involving no more than three muscle groups at any one time.

B. Unvarying intensity of the tics over weeks or months.

C. Ability to suppress the movements voluntarily for minutes to hours.

D. Duration of at least one year.

307.23 Tourette's Disorder

The essential features are recurrent, involuntary, repetitive, rapid movements (tics), including multiple vocal tics. The movements can be voluntarily suppressed for minutes to hours; and the intensity, frequency, and location of the symptoms vary over weeks or months.

The tics typically involve the head and, frequently, other parts of the body, such as the torso and upper and lower limbs. The vocal tics include various sounds such as clicks, grunts, yelps, barks, sniffs, and coughs, or words. Coprolalia, an irresistible urge to utter obscenities, is present in 60% of the cases. All of the symptoms are exacerbated by stress. They disappear, however, during sleep, and may become attenuated during some absorbing activities. Although the tics can be voluntarily suppressed, they eventually reappear.

Associated features. There may be other symptoms, such as echokinesis (imitation of the movements of someone who is being observed), palilalia (repetition of one's own last words or phrases), mental coprolalia (thinking about curse words), obsessive thoughts of doubting, and compulsive impulses to touch things or to perform complicated movements, such as squatting, deep knee bends, retracing steps, and twirling when walking.

Nonspecific EEG abnormalities, soft neurological signs, central nervous system psychological test abnormalities, hyperactivity or perceptual problems during infancy and childhood, or organic stigmata occur in about half the individuals with the disorder.

Age at onset. The disorder may appear as early as 2 years of age, and almost always appears before the age of 13.

Course. The disorder is usually lifelong, though brief periods of remission may occur. In some cases the disorder disappears before adulthood.

In approximately half the cases, the first symptom to appear is a single tic, most frequently an eye blink, less frequently a tic of another part of the face or the body. Initial symptoms also include tongue protrusion, squatting, sniffing, hopping, skipping, throat clearing, stuttering, uttering sounds or words, and coprolalia. Other cases begin with multiple symptoms, which may include any combination of the previously described tics and various noises such as barks, grunts, screams, yelps, or snorts.

Complications. In rare cases suicide may be a complication, because of despair over the disruptive effect of the disorder on social and occupational functioning.

Predisposing factors. There are no known predisposing factors. The disorder is unrelated to social class, or history of other mental disorders in the family or in the individual.

Prevalence. The estimated lifetime prevalence rate ranges from 0.1 to 0.5 per thousand.

Sex ratio. The disorder is three times more common in boys than in girls.

Familial pattern. Tics of various kinds are apparently more common among family members than in the general population.

Differential diagnosis. See differential diagnosis of tics, page 73. **Amphetamine Intoxication, cerebrovascular accidents, Lesch-Nyhan syndrome, Wilson's disease, Sydenham's and Huntington's chorea, multiple sclerosis, Schizophrenia, general paresis,** and **Organic Mental Disorders** may present with abnormal motor movements. These disorders can readily be distinguished from Tic Disorders because they have distinguishing symptoms, signs, clinical course, and physiological abnormalities as revealed by laboratory tests; and none of them have vocalizations similar to the clicks, grunts, yelps, barks, sniffs, coughs, and words of Tourette's Disorder.

Diagnostic criteria for Tourette's Disorder

A. Age at onset between 2 and 15 years.

B. Presence of recurrent, involuntary, repetitive, rapid, purposeless motor movements affecting multiple muscle groups.

C. Multiple vocal tics.

D. Ability to suppress movements voluntarily for minutes to hours.

E. Variations in the intensity of the symptoms over weeks or months.

F. Duration of more than one year.

307.20 Atypical Tic Disorder

This category is for the diagnosis of tics that cannot be adequately classified in any of the previous categories.

307.30 Atypical Stereotyped Movement Disorder

This category is for conditions such as head banging, rocking, repetitive hand movements consisting of quick, rhythmic, small hand rotations, or repetitive voluntary movements that typically involve the fingers or arms. These disorders are distinguishable from tics in that they consist of voluntary movements and are not spasmodic. Moreover, unlike individuals with a Tic Disorder, those with these conditions are not distressed by the symptoms and may even appear to derive enjoyment from the repetitive activities. Though bizarre posturing or movements may occur in adults, these conditions are found almost exclusively in children. They are especially prevalent among individuals with Mental Retardation or Pervasive Developmental Disorders and among children suffering from grossly inadequate social stimulation, but they may also occur in the absence of a concurrent mental disorder.

OTHER DISORDERS WITH PHYSICAL MANIFESTATIONS

This subclass of disorders includes categories in which the predominant disturbance is in a physical function: Stuttering (speech), Functional Enuresis and Functional Encopresis (urination and defecation), Sleepwalking Disorder and Sleep Terror Disorder (sleep). The inclusion of these categories in a classification of mental disorders is justified partly by tradition in that, formerly, psychological conflict was thought to play a central role in all of these disorders and it was thought that these conditions were almost always associated with other signs of psychopathology. Recently, however, many have come to question these assumptions, at least with regard to some of these categories. Further, there is evidence that most of the children with these disorders do not have associated mental disorder.

307.00 Stuttering

The essential features are frequent repetitions or prolongations of sounds, syllables, or words, or frequent, unusual hesitations and pauses that disrupt the rhythmic flow of speech. The extent of the disturbance varies from situation to situation and is most severe when there is special pressure to communicate, as during a job interview.

Speech may be very rapid or very slow, and there may be inappropriate inflection or lack of variation in pitch. In even the most severe cases, Stuttering is often absent during oral reading, singing, or talking to inanimate objects or to pets.

Stammering is a synonym for Stuttering.

Associated features. In moderate or severe cases there is vivid, fearful anticipation of stuttering with avoidance of particular sounds, words, or situations in which stuttering is anticipated. In addition, there may be eye blinks, tics, tremors of the lips or jaw, or jerking of the head.

Age at onset. Stuttering usually appears before the age of 12, with sharp peaks of onset between the ages of 2 to 3½ and 5 to 7 years.

Course. Typically the disturbance starts gradually with repetition of initial consonants, whole words that are usually the first words of a phrase, or long words. The child is generally not aware of the stuttering. As the disorder progresses, the repetitions become more frequent, and the stuttering occurs on the most important words of phrases. The child becomes aware of the speech difficulty, and in certain situations some words and sounds become more difficult.

The usual course is chronic, with periods of partial remission extending for weeks or months and exacerbations that occur most frequently when there is particular pressure to communicate. Between 50% and 80% of children with the disorder recover spontaneously; this is most likely in mild cases.

Impairment. Teasing and social ostracism by peers may result in impairment in peer relations. The child may have academic difficulties if he or she avoids speaking in class.

Complications. Limitation in occupational choice or advancement is the principal complication.

Predisposing factors. No information.

Prevalence. Approximately 1% of all children have a persistent problem with Stuttering that continues into adolescence.

Sex ratio. The disorder is about four times more common in males than in females.

Familial pattern. Stuttering is more common among family members than in the general population.

Differential diagnosis. Spastic dysphonia, a stuttering-like speech disorder, is distinguished from Stuttering by the presence of an abnormal pattern of breathing.

Cluttering, in which there is such a rapid rate of speech that fluency breaks down, may suggest Stuttering, but in cluttering the individual is usually unaware of the disturbance, whereas in Stuttering, after the initial phase, the individual is painfully aware of the disturbance.

Diagnostic criteria for Stuttering

Frequent repetitions or prolongations of sounds, syllables, or words or frequent, unusual hesitations and pauses that disrupt the rhythmic flow of speech.

307.60 Functional Enuresis

The essential feature is repeated involuntary voiding of urine during the day or at night, after an age at which continence is expected, that is not due to any physical disorder. The disorder is somewhat arbitrarily defined as involuntary voiding of urine at least twice a month for children between the ages of five and six and once a month for older children.

Functional Enuresis is often referred to as *primary* if it has not been preceded by a period of urinary continence for at least one year, and *secondary* if it has been preceded by a period of urinary continence for at least one year. Either of the above types may be *nocturnal* (most common), defined as the passage of urine during sleep time only, *diurnal,* defined as the passage of urine during waking hours, or *both* diurnal and nocturnal. There is no provision for coding these distinctions.

In most cases of nocturnal Functional Enuresis, the child awakens with no memory of a dream and no memory of having urinated because typically the disturbance occurs during the first third of the night, during non-REM sleep. However, in a few cases the voiding takes place during the rapid eye movement (REM) stage of sleep, and in such cases the child may recall a dream that involved the act of urinating.

Associated features. Very often the individual feels ashamed or embarrassed and may wish to avoid situations that might lead to embarrassment, such as camp or overnight visits to friends. Although the great majority of children with Functional Enuresis do not have a coexisting mental disorder, the prevalence of coexisting mental disorders is greater in individuals with Functional Enuresis than in the general population.

Functional Encopresis, Sleepwalking Disorder, and Sleep Terror Disorder may also be present.

Course. Most children with the disorder eventually become continent by adolescence, but in some cases the disorder continues into adulthood.

Age at onset. Primary Functional Enuresis by definition begins by age five. Most cases of secondary Functional Enuresis have their onset between the ages of five and eight.

Impairment. The amount of impairment is primarily a function of the effect on the individual's self-esteem, the degree of social ostracism by peers, and anger, punishment, and rejection from caretakers.

Complications. A complication is ascending urinary infection (particularly in girls).

Predisposing factors. These include delay in the development of the supporting musculature of the bladder, impaired ability of the bladder to adapt to urinary filling without changes in intravesical pressure with a lower bladder volume threshold for involuntary voiding, delayed or lax toilet training, and psychosocial stress (particularly hospitalization between the ages of two and four, entering school, and the birth of a sibling).

Prevalence and sex ratio. The prevalence of Functional Enuresis as defined here is: at age 5, 7% for boys, and 3% for girls; at age 10, 3% for boys, and 2% for girls; and at age 18, 1% for boys, and almost nonexistent for girls.

Familial pattern. Approximately 75% of all children with Functional Enuresis have a first-degree relative who has or has had the disorder. The concordance for the disorder is greater in monozygotic than in dizygotic twins.

Differential diagnosis. Organic causes of enuresis such as diabetes and seizure disorder should be ruled out by appropriate physical examination.

Diagnostic criteria for Functional Enuresis

A. Repeated involuntary voiding of urine by day or at night.

B. At least two such events per month for children between the ages of five and six, and at least one event per month for older children.

C. Not due to a physical disorder, such as diabetes or a seizure disorder.

307.70 Functional Encopresis

The essential feature is repeated voluntary or involuntary passage of feces of normal or near-normal consistency into places not appropriate for that purpose in the individual's own sociocultural setting, not due to any physical disorder.

Functional Encopresis is generally referred to as *primary* if it occurs after the child has reached the age of four and has not been preceded by fecal continence for at least one year and *secondary* if it has been preceded by a period of fecal continence for at least one year. There is no provision for recording the primary-secondary distinction. When the passage of feces in Functional Encopresis is involuntary rather than deliberate, it is often related to constipation, impaction, or retention with subsequent overflow. In such cases there often is soiling of clothes shortly after bathing because of reflex stimulation.

Associated features. Very often the individual feels ashamed or embarrassed and may wish to avoid situations that might lead to embarrassment, such as camp or overnight visits to friends. When the incontinence is clearly deliberate, antisocial and other psychopathological features are common. Smearing feces may be deliberate, and should be differentiated from smearing that takes place accidentally in the child's attempt to clear or hide feces passed involuntarily. Twenty-five percent of children with Functional Encopresis also have Functional Enuresis.

Course. Functional Encopresis rarely becomes chronic.

Age at onset. By definition primary Functional Encopresis begins by age four. Secondary Functional Encopresis usually begins between the ages of four and eight.

Impairment. The amount of impairment is primarily a function of the effect on the individual's self-esteem, the degree of social ostracism by peers, and anger, punishment, and rejection from caretakers.

Complications. None.

Predisposing factors. These include inadequate, inconsistent toilet training and psychosocial stress, such as entering school and the birth of a sibling.

Prevalence. It is estimated that approximately 1% of five-year-olds have the disorder. Primary Functional Encopresis apparently is more frequent in the lower socioeconomic classes.

Sex ratio. The disorder is more common in males than in females.

Familial pattern. No information.

Differential diagnosis. Functional Encopresis must be differentiated from **structural organic causes of encopresis**, such as **aganglionic megacolon** and **anal fissure**, which need to be ruled out by physical examination.

Diagnostic criteria for Functional Encopresis

A. Repeated voluntary or involuntary passage of feces of normal or near-normal consistency into places not appropriate for that purpose in the individual's own sociocultural setting.

B. At least one such event a month after the age of four.

C. Not due to a physical disorder, such as aganglionic megacolon.

307.46 Sleepwalking Disorder

The essential features are repeated episodes of a sequence of complex behaviors that frequently, though not always, progress—without full consciousness or later memory of the episode—to leaving bed and walking about. The episode usually occurs between 30 and 200 minutes after onset of sleep (the interval of nonrapid eye movement [NREM] sleep that typically contains EEG delta activity, sleep stages 3 and 4) and lasts from a few minutes to about a half hour.

During a typical epsiode the individual sits up and carries out perseverative motor movements, such as picking at the blanket, and then performs semi-purposeful motor acts, which, in addition to walking, may include dressing, opening doors, eating, and going to the bathroom. The episode may terminate before the walking stage is reached.

During the episode the individual has a blank, staring face and is relatively unresponsive to the efforts of others to influence the sleepwalking or to communicate with him or her, and can be awakened only with great difficulty. During sleepwalking, coordination is poor; but the individual is able to see and walks around objects in his or her path. It is a myth that during sleepwalking the individual is careful and safe; in fact, he or she can stumble or lose balance and be injured by taking hazardous routes such as through windows or down fire escapes.

The walking behavior may terminate spontaneously by awakening followed by several minutes of disorientation. On the other hand, the individual may return to bed without ever reaching consciousness, or may lie down in another place to continue sleep, though mystified the next morning to find himself or herself there.

Upon awakening (either from the sleepwalking episode or the next morning), there is amnesia for the route traversed and what happened during the episode. Fragmentary dream images may be recalled, but not complete dream sequences.

Sleep EEG slow waves usually increase in amplitude in stage 4 sleep just preceding the episode; but EEG flattening, i.e., arousal, may occur before the episode. In the usual instance, as walking ensues, the high amplitude, slow wave pattern gives way to an admixture of NREM stages and lower amplitude EEG alpha activity.

Episodes are more likely if the individual is fatigued, has experienced a stress, or has taken a bedtime dose of a sedative or hypnotic substance.

Associated features. Frenzied behavior or aggression to persons or objects is infrequent. Sleeptalking may occur during sleepwalking, but articulation is poor; dialogue is rare.

Individuals with Sleepwalking Disorder have a higher than normal incidence of other episodic disorders associated with deep NREM sleep, such as nocturnal Functional Enuresis and Sleep Terror Disorder. There is no consistently associated psychopathology in children with this disorder. In contrast, adults with the disorder frequently do show evidence of other mental disorders, such as Personality Disorders.

Age at onset. Sleepwalking Disorder usually begins between ages 6 and 12. Adults who sleepwalk give a history of childhood episodes, then a period of remission until recurrence in the 20s and 30s.

Course. Sleepwalking usually lasts several years in children and adolescents, whether it occurs infrequently or nightly. The great majority of children or adolescents with the disorder are asymptomatic by their 20s; the disturbance tends to be more chronic in adults.

Impairment. Impairment is limited to avoidance of situations in which others might become aware of the disturbance, such as camp or overnight visits to friends.

Complications. Accidental injury during the episodes is the major complication.

Predisposing factors. Seizure disorders, CNS infections, and trauma are predisposing factors.

Prevalence. It is estimated that 1%–6% of children at some time have the disorder. As many as 15% of all children experience isolated episodes. Sleepwalking Disorder is rarer in adults.

Sex ratio. The disorder is apparently more common in males than in females.

Familial pattern. The disorder is more common among family members than in the general population. Family members of individuals with Sleepwalking Disorder tend to be deep sleepers.

Differential diagnosis. Psychomotor epileptic seizures may occur at night and produce episodes of perseverative behaviors similar to sleepwalking except that the individuals almost never return to their own beds. Also, during epileptic attacks there is total unreactivity to environmental stimuli, and perseverative motor movements such as swallowing and rubbing the hands are more common. Individuals with seizure disorders generally manifest such behaviors in the waking state as well, and the activity is associated with recordable seizure discharge. However, seizure disorders do not preclude coexisting Sleepwalking Disorder.

Psychogenic Fugues are distinguishable from Sleepwalking Disorder on several counts: Psychogenic Fugues are rare in children, typically begin in wakefulness, have a duration of hours or days, are not characterized by disturbances of consciousness, and are usually associated with other evidence of severe psychopathology.

Sleep drunkenness (prolonged transition to a clear consciousness after awakening) may resemble Sleepwalking Disorder except for the former's appearance in the morning and high frequency of aggressive behavior.

Diagnostic criteria for Sleepwalking Disorder

A. There are repeated episodes of arising from bed during sleep and walking about for several minutes to a half hour, usually occurring between 30 and 200 minutes after onset of sleep (the interval of sleep that typically contains EEG delta activity, sleep stages 3 and 4).

B. While sleepwalking, the individual has a blank, staring face; is relatively unresponsive to the efforts of others to influence the sleepwalking or to communicate with him or her; and can be wakened only with great difficulty.

C. Upon awakening (either from the sleeping episode or the next morning), the individual has amnesia for the route traversed and for what happened during the episode.

D. Within several minutes of awakening from the sleepwalking episode, there is no impairment of mental activity or behavior (although there may initially be a short period of confusion or disorientation).

E. There is no evidence that the episode occurred during REM sleep or that there is abnormal electrical brain activity during sleep.

307.46 Sleep Terror Disorder

The essential features are repeated episodes of abrupt awakening from sleep, usually beginning with a panicky scream. The episode usually occurs between 30 and 200 minutes after onset of sleep (the interval of nonrapid eye movement [NREM] sleep that typically contains EEG delta activity, sleep stages 3 and 4), and lasts 1 to 10 minutes. This condition has also been called Pavor Nocturnus.

During a typical episode, the individual sits up in bed with intense anxiety and displays agitated and perseverative motor movements (such as picking at the blanket), a frightened expression, dilated pupils, profuse perspiration, piloerection, rapid breathing, and quick pulse. An individual in this state is unresponsive to efforts of others to comfort him or her until the agitation and confusion subside. The individual may then recount having had a sense of terror and fragmentary dream images before arousal, but rarely a vivid and complete dream sequence. Morning amnesia for the entire episode is the rule. Episodes are

more likely if the individual is fatigued, has experienced a stress, or has taken a bedtime dose of a tricyclic antidepressant or neuroleptic.

Prior to a severe episode, the sleep EEG delta waves may be higher in amplitude than usual for the NREM phase of sleep, and breathing and heartbeat, slower. The onset of the episode is accompanied by a twofold to fourfold increase in heart rate, and the EEG quickly assumes an alpha pattern.

Associated features. There is no consistently associated psychopathology in children with this disorder. In contrast, adults with the disorder frequently do show evidence of other mental disorders, such as Generalized Anxiety Disorder.

Age at onset. Sleep Terror Disorder usually begins between ages 4 and 12. When the disorder begins in adulthood, it usually begins in the 20s or 30s; onset after 40 is rare.

Course. Episodes are extremely variable in frequency both within and among individuals, and usually occur at intervals of days or weeks, but may occur on consecutive nights. In children the disorder usually gradually disappears in early adolescence. When the disorder begins in adulthood, the course is often chronic.

Impairment. Impairment is limited to avoidance of situations in which others might become aware of the disturbance, such as camp or overnight visits to friends.

Complications. None.

Predisposing factors. No information.

Prevalence. It is estimated that 1% to 4% of children at some time have the disorder. A much greater proportion of children experience isolated episodes.

Sex ratio. The disorder is more common in males than in females.

Familial pattern. The disorder is apparently more common among family members than in the general population.

Differential diagnosis. REM sleep nightmares are distinguished from Sleep Terror Disorder by their appearance in the middle and latter thirds of the night, the milder anxiety experience, the absence of a panicky scream upon awakening, and the distinct recall of a detailed dream sequence in which a growing threat leads to awakening. Parents may misinterpret the fearfulness and fragmentary imagery reports of Sleep Terror Disorder as indicative of a REM sleep nightmare. **Hypnagogic hallucinations** may be associated with anxiety, but occur at onset of sleep and are vivid images at the transition from wakefulness to sleep. **Epileptic seizures** during sleep with postictal confusion may present a clinical picture similar to Sleep Terror Disorder, but the presence of epileptic seizures in the waking state or the presence of an abnormal sleep EEG rules out a diagnosis of Sleep Terror Disorder.

Diagnostic criteria for Sleep Terror Disorder

A. Repeated episodes of abrupt awakening (lasting 1-10 minutes) from sleep, usually occurring between 30 and 200 minutes after onset of sleep (the interval of sleep that typically contains EEG delta activity, sleep stages 3 and 4) and usually beginning with a panicky scream.

B. Intense anxiety during the episode and at least three of the following signs of autonomic arousal:

(1) tachycardia
(2) rapid breathing
(3) dilated pupils
(4) sweating
(5) piloerection

C. Relative unresponsiveness to efforts of others to comfort the individual during the episode and, almost invariably, confusion, disorientation, and perseverative motor movements (e.g., picking at pillow).

D. No evidence that the episode occurred during REM sleep or of abnormal electrical brain activity during sleep.

PERVASIVE DEVELOPMENTAL DISORDERS

The disorders in this subclass are characterized by *distortions* in the development of multiple basic psychological functions that are involved in the development of social skills and language, such as attention, perception, reality testing, and motor movement.

In the past, children with these disorders have been described by many terms: Atypical Children, Symbiotic Psychotic Children, Childhood Schizophrenia, and others. Since these disorders apparently bear little relationship to the psychotic disorders of adult life, the term "psychosis" has not been used here in the name of this group of conditions. The term Pervasive Developmental Disorder has been selected because it describes most accurately the core clinical disturbance: many basic areas of psychological development are affected at the same time and to a severe degree.

Pervasive Developmental Disorders differ from the Specific Developmental Disorders in two basic ways. First, only a single specific function is affected in each Specific Developmental Disorder whereas in Pervasive Developmental Disorders multiple functions are always affected. Second, in Specific Developmental Disorders the children behave as if they are passing through an earlier normal developmental stage, because the disturbance is a *delay* in development, whereas children with Pervasive Developmental Disorders display severe qualitative abnormalities that are not normal for any stage of development, because the disturbance is a *distortion* in development.

The fifth digit should be used for all of the Pervasive Developmental Disorders to indicate whether the full syndrome is currently present (code=0) or

whether the full syndrome occurred previously, but now the individual has only residual symptoms of the disorder, such as blunted or inappropriate affect, social withdrawal, or eccentric behavior (code=1).

The ICD-9 category Disintegrative Psychosis is not included in this classification since the disorder apparently is a nonspecific Organic Brain Syndrome that consists of a Dementia plus other behavioral abnormalities, such as rapid loss of language and social skills. Such cases should be diagnosed as Dementia.

299.0x Infantile Autism

The essential features are a lack of responsiveness to other people (autism), gross impairment in communicative skills, and bizarre responses to various aspects of the environment, all developing within the first 30 months of age. Infantile Autism may be associated with known organic conditions, such as maternal rubella or phenylketonuria. In such cases the behavioral syndrome Infantile Autism should be recorded on Axis I, and the physical disorder, on Axis III.

The relationship of this category to Schizophrenia is controversial. Some believe that Infantile Autism is the earliest form of Schizophrenia, whereas others believe that they are two distinct conditions. However, there is apparently no increased incidence of Schizophrenia in the families of children with Infantile Autism, which supports the hypothesis that the two disorders are unrelated.

The failure to develop interpersonal relationships is characterized by a lack of responsiveness to and a lack of interest in people, with a concomitant failure to develop normal attachment behavior. In infancy these deficiencies may be manifested by a failure to cuddle, by lack of eye contact and facial responsiveness, and by indifference or aversion to affection and physical contact. As a result, parents often suspect that the child is deaf. Adults may be treated as interchangeable, or the child may cling mechanically to a specific individual.

In early childhood there is invariably failure to develop cooperative play and friendships; but, as the children grow older, greater awareness of and attachment to parents and other familiar adults often develop. Some of the least handicapped may eventually reach a stage where they can become passively involved in other children's games or physical play such as running with other children. This apparent sociability is superficial, however, and can be a source of diagnostic confusion if mistaken for social relatedness when the diagnosis is made retrospectively.

Impairment in communication includes both verbal and nonverbal skills. Language may be totally absent. When it develops, it is often characterized by: immature grammatical structure, delayed or immediate echolalia, pronominal reversals (use of the pronoun "you" when "I" is the intended meaning), nominal aphasia (inability to name objects), inability to use abstract terms, metaphorical language (utterances whose usage is idiosyncratic and whose meaning is not clear), and abnormal speech melody, such as questionlike rises at ends of statements. Appropriate nonverbal communication, such as socially appropriate facial expressions and gestures, is often lacking.

Bizarre responses to the environment may take several forms. There may be resistance and even catastrophic reactions to minor changes in the environment,

e.g., the child may scream when his or her place at the dinner table is changed. There is often attachment to odd objects, e.g., the child insists on always carrying a string or rubber band. Ritualistic behavior may involve motor acts, such as hand clapping or repetitive peculiar hand movements, or insisting that fixed sequences of events precede going to bed. The fascination with movement may be exemplified by staring at fans, and the child may display inordinate interest in spinning objects. Music of all kinds may hold a special interest for the child. The child may be extremely interested in buttons, parts of the body, playing with water, or peculiar rote topics such as train schedules or historical dates. Tasks involving long-term memory, for example, recall of the exact words of songs heard years before, may be performed remarkably well.

Associated features. Mood may be labile; crying may be unexplained or inconsolable; there may be giggling or laughing without identifiable cause. There is often underresponsiveness or overresponsiveness to sensory stimuli, such as light, pain, or sound. Real dangers, such as moving vehicles and heights, may not be appreciated. Peculiar nervous habits, such as hair pulling or biting parts of the body, are sometimes present. Rocking or other rhythmic body movements also occur.

About 40% of children with the disorder have an IQ below 50; only 30% have an IQ of 70 or more. These children show extreme variability in intellectual functioning; they are often untestable on verbal tasks, and when testable, performance is worst on tasks demanding symbolic or abstract thought and sequential logic. However, tasks requiring manipulative or visual-spatial skills or immediate memory may be performed well.

Age at onset. By definition, the age at onset is always before 30 months. However, it may be difficult to establish age at onset retrospectively unless those who cared for the child during the early years are able to give accurate information about language development, sociability, and play. Parents of only children may be unaware of the problems until the child is observed with other children. The parents may then date the age at onset from that point, although a careful history will usually reveal that the abnormalities were present earlier.

Course. The disorder is chronic. Some of these children eventually are able to lead independent lives, with only minimal signs of the essential features of the disorder; but often the social awkwardness and ineptness persist (Residual State). Overall, one child in six makes an adequate social adjustment and is able to do some kind of regular work by adulthood; another one in six makes only a fair adjustment; and two-thirds remain severely handicapped and unable to lead independent lives. Factors related to long-term prognosis include IQ and development of language skills.

Impairment. The disorder is extremely incapacitating, and special educational facilities are almost always necessary.

Complications. The major complication is the development of epileptic sei-

zures secondary to an underlying physical disorder; about 25% or more of cases develop seizures in adolescence or early adult life. Most of the children with an IQ below 50 develop seizures, but only very few of those with normal intelligence do so.

Prevalence. The disorder is very rare (2-4 cases per 10,000). It is apparently more common in the upper socioeconomic classes, but the reason for this is not clear.

Sex ratio. The disorder is about three times more common in boys than in girls.

Predisposing factors. Maternal rubella (especially when associated with infantile deafness or blindness), phenylketonuria, encephalitis, meningitis, and tuberous sclerosis are among the predisposing factors. In the past, certain familial interpersonal factors were thought to predispose to the development of this syndrome, but recent studies do not support this view.

Familial pattern. The prevalence of Infantile Autism is 50 times as great in siblings of children with the disorder than in the general population.

Differential diagnosis. In **Mental Retardation** there are often behavioral abnormalities similar to those seen in Infantile Autism. However, the full syndrome of Infantile Autism is rarely present. When both disorders are present, both diagnoses should be made. In **Schizophrenia occurring in childhood** there are oddities of behavior; but typically there are hallucinations, delusions, and loosening of associations or incoherence, which are not present in Infantile Autism. In **Childhood Onset Pervasive Developmental Disorder**, the age at onset is later than in Infantile Autism and the full syndrome of Infantile Autism is not present. In children with **hearing impairments** there will be a history of responding consistently only to very loud sounds, whereas in Infantile Autism the response to sounds is inconsistent. An audiogram can rule out the possibility of hearing impairment. In **Developmental Language Disorder, Receptive Type**, the children generally make eye contact and will often try to communicate appropriately by means of gestures, whereas in Infantile Autism there is a pervasive lack of responsiveness.

Diagnostic criteria for Infantile Autism

A. Onset before 30 months of age.

B. Pervasive lack of responsiveness to other people (autism).

C. Gross deficits in language development.

D. If speech is present, peculiar speech patterns such as immediate and delayed echolalia, metaphorical language, pronominal reversal.

E. Bizarre responses to various aspects of the environment, e.g., resistance to change, peculiar interest in or attachments to animate or inanimate objects.

F. Absence of delusions, hallucinations, loosening of associations, and incoherence as in Schizophrenia.

299.00 Infantile Autism, Full Syndrome Present
Currently meets the criteria for Infantile Autism.

299.01 Infantile Autism, Residual State

Diagnostic criteria for Infantile Autism, Residual State
A. Once had an illness that met the criteria for Infantile Autism.

B. The current clinical picture no longer meets the full criteria for Infantile Autism, but signs of the illness have persisted to the present, such as oddities of communication and social awkwardness.

299.9x Childhood Onset Pervasive Developmental Disorder
The essential features are a profound disturbance in social relations and multiple oddities of behavior, all developing after 30 months of age and before 12 years.

The disturbance in social relationships is gross and sustained, with such symptoms as lack of appropriate affective responsivity, inappropriate clinging, asociality, and a lack of peer relationships.

Oddities of behavior include: sudden excessive anxiety, constricted or inappropriate affect, resistance to change in the environment or insistence on doing things in the same manner every time, oddities of motor movement, speech abnormalities, hyper- or hypo-sensitivity to sensory stimuli, and self-mutilation. Examples of these behaviors are given in the diagnostic criteria.

Associated features. Frequently there are bizarre ideas and fantasies and preoccupation with morbid thoughts or interests. There may be pathological preoccupation with and attachment to objects, such as always carrying a string or rubber band. The disorder is particularly common in children with low IQs.

Age at onset. By definition the age at onset is after 30 months and before 12 years of age.

Course. The course is chronic. The long-term prognosis is probably better than that of Infantile Autism.

Impairment. The disorder is extremely incapacitating, and special educational facilities are regularly necessary.

Complications. The major complication is inability to function independently and the consequent continued need for supervision and financial support.

Predisposing factors. No information.

Prevalence. This is an extremely rare disorder.

Sex ratio. The disorder is far more common in boys than in girls.

Familial pattern. No information.

Differential diagnosis. In **Schizotypal Personality Disorder** there are also oddities of behavior and communication, but any disturbance in social relations is mild in comparison with the profound disturbance present in Childhood Onset Pervasive Developmental Disorder. Furthermore, symptoms such as disturbances in motor movement, inappropriate affect, and self-mutilation are not present in Schizotypal Personality Disorder.

For a discussion of the differential diagnosis with other conditions, see Infantile Autism, p. 89.

Diagnostic criteria for Childhood Onset Pervasive Developmental Disorder

A. Gross and sustained impairment in social relationships, e.g., lack of appropriate affective responsivity, inappropriate clinging, asociality, lack of empathy.

B. At least three of the following:

(1) sudden excessive anxiety manifested by such symptoms as free-floating anxiety, catastrophic reactions to everyday occurrences, inability to be consoled when upset, unexplained panic attacks
(2) constricted or inappropriate affect, including lack of appropriate fear reactions, unexplained rage reactions, and extreme mood lability
(3) resistance to change in the environment (e.g., upset if dinner time is changed), or insistence on doing things in the same manner every time (e.g., putting on clothes always in the same order)
(4) oddities of motor movement, such as peculiar posturing, peculiar hand or finger movements, or walking on tiptoe
(5) abnormalities of speech, such as questionlike melody, monotonous voice
(6) hyper- or hypo-sensitivity to sensory stimuli, e.g., hyperacusis
(7) self-mutilation, e.g., biting or hitting self, head banging

C. Onset of the full syndrome after 30 months of age and before 12 years of age.

D. Absence of delusions, hallucinations, incoherence, or marked loosening of associations.

299.90 Childhood Onset Pervasive Developmental Disorder, Full Syndrome Present

Currently meets the criteria for Childhood Onset Pervasive Developmental Disorder.

299.91 Childhood Onset Pervasive Developmental Disorder, Residual State

Diagnostic criteria for Childhood Onset Pervasive Developmental Disorder, Residual State

A. Once had an illness that met the criteria for Childhood Onset Pervasive Developmental Disorder.

B. The current clinical picture no longer meets the full criteria for the disorder, but signs of the illness have persisted to the present, such as oddities of communication and social awkwardness.

299.8x Atypical Pervasive Developmental Disorder

This category should be used for children with distortions in the development of multiple basic psychological functions that are involved in the development of social skills and language and that cannot be classified as either Infantile Autism or Childhood Onset Pervasive Developmental Disorder.

SPECIFIC DEVELOPMENTAL DISORDERS (AXIS II)

This subclass is for disorders of specific areas of development not due to another disorder. For example, a delay in language development in an otherwise normal child would be classified as a Specific Developmental Disorder whereas a delay in language development in a child with Infantile Autism would be attributed to the Infantile Autism and therefore would not be classified as a Specific Developmental Disorder. Similarly, an individual with general delays in development would receive a diagnosis of Mental Retardation, not a Specific Developmental Disorder.

Each aspect of development noted here is related to biological maturation. However, there is no assumption regarding the primacy of biological etiological factors, and nonbiological factors are clearly involved in these disorders.

The inclusion of these categories in a classification of "mental disorders" is controversial, since many of the children with these disorders have no other signs of psychopathology, and the detection and treatment of the most common category, Developmental Reading Disorder, take place mainly within the educational system rather than the mental health system. Nevertheless, these conditions fall within the DSM-III concept of mental disorder (see p. 6); moreover, they are included in the mental disorders section of ICD-9 (see Appendix D).

Because Specific Developmental Disorders occur so frequently in conjunction with other disorders, they are coded on a separate axis (Axis II) to ensure that they are not overlooked. Thus, in the case of a child with Conduct Disorder and Developmental Reading Disorder, the Conduct Disorder will be coded on

Axis I, and the reading disorder on Axis II. A particular child may have more than one Specific Developmental Disorder; all should be diagnosed.

Although most of the clinical features seen in Specific Developmental Disorders represent functional levels that are normal for very young children (e.g., inability to do arithmetic), there is no implication that children with these disorders are simply at a lower end of a normal continuum and that they will "catch up" with time. In fact, children with these disorders frequently continue to show signs of the disturbance as adolescents or as adults; and the relevant diagnosis should be noted when an adult still has clinically significant signs of the disorder.

Age at onset. In these disorders onset is related to the age at which each area of functioning is expected to begin to develop. Thus, Developmental Language and Articulation Disorders may be first recognized within the first three years of life, when speech normally develops; and Developmental Reading and Arithmetic Disorders are first recognized in the first few years of school, when these skills normally develop.

Course. In most cases the disturbance is stable throughout childhood and adolescence, and many individuals continue to show some attenuated signs of the disturbance in adult life. More rarely, especially in mild cases, there is marked improvement in, or even disappearance of, all symptoms in time.

Impairment. Invariably there is some degree of impairment in academic functioning. The overall level of impairment is most marked when language or articulation is affected.

Complications. Academic failure, truancy, and antisocial behavior are among the commonly observed complications.

Predisposing factors. Factors that predispose one to most of these disorders are generally unknown. However, being a twin, being born prematurely or of an older mother, or sustaining a head injury apparently predispose to Developmental Reading Disorder.

Sex ratio. No information is available for Developmental Arithmetic Disorder. The other Specific Developmental Disorders are all about twice as common in males as in females.

315.00 Developmental Reading Disorder

The essential feature is significant impairment in the development of reading skills not accounted for by chronological age, mental age, or inadequate schooling. In addition, in school, the child's performance on tasks requiring reading skills is significantly below his or her intellectual capacity. "Significant" impairment differs somewhat with age: a one-to-two-year discrepancy in reading skill for ages 8 to 13 is significant, but below that age, it is difficult to specify how great a discrepancy is significant.

This disorder has been referred to as "dyslexia." Faulty oral reading occurs, often characterized by omissions, additions, and distortions of words. Reading

is slow, and often there is reduced reading comprehension, although the ability to copy from written or printed texts is generally unaffected.

The diagnosis can be made only by individually administered IQ tests that contain verbal subtests and that yield a level of full-scale IQ, plus a variety of academic achievement tests that contain reading subtests.

Associated features. In spelling to dictation there may be numerous and bizarre errors that are not explainable by phonetics or by simple reversal of letters (such as b—d). Other common associated features include subtle language difficulties, such as impaired sound discrimination and difficulties with sequencing words properly, and behavioral problems, such as those associated with Attention Deficit Disorder and Conduct Disorder. "Soft" neurological signs, such as finger agnosia, may be found, particularly in younger children.

Prevalence. The disorder is apparently common.

Familial pattern. Reading difficulty and speech and language problems are more common in family members than in the general population.

Differential diagnosis. In Mental Retardation, reading difficulty is due to a general impairment in intellectual functioning. However, in some cases of Mild Mental Retardation, the reading level is significantly below the expected level, given the individual's schooling and level of retardation. In such cases the additional diagnosis of Developmental Reading Disorder should be made, since treatment of the reading difficulties can greatly increase occupational potential.

Inadequate schooling can result in poor performance on standardized reading tests. In such cases, however, other children in the school will generally have similar difficulty. **Impaired vision or hearing** may affect reading ability, and can be ruled out with screening tests.

Diagnostic criteria for Developmental Reading Disorder

Performance on standardized, individually administered tests of reading skill is significantly below the expected level, given the individual's schooling, chronological age, and mental age (as determined by an individually administered IQ test). In addition, in school, the child's performance on tasks requiring reading skills is significantly below his or her intellectual capacity.

315.10 Developmental Arithmetic Disorder

The essential feature is significant impairment in the development of arithmetic skills not accounted for by chronological age, mental age, or inadequate schooling. In addition, in school, the child's performance on tasks requiring arithmetic skills is significantly below his or her intellectual capacity. The diagnosis can be made only by individually administered IQ tests that yield a level of full-scale IQ, plus a variety of academic achievement tests containing arithmetic subtests.

Associated features. Other academic problems, including reading and spell-

ing difficulty, are often present; but generally the degree of these deficits is not as pronounced.

Prevalence. The disorder is apparently not common.

Familial pattern. No information.

Differential diagnosis. See Developmental Reading Disorder (p. 94).

Diagnostic criteria for Developmental Arithmetic Disorder

Performance on standardized, individually administered tests of arithmetic achievement is significantly below expected level, given the individual's schooling, chronological age, and mental age (as determined by an individually administered IQ test). In addition, in school, the child's performance on tasks requiring arithmetic skills is significantly below his or her intellectual capacity.

315.31 Developmental Language Disorder

There are three major types of language disorder: (1) failure to acquire any language, (2) acquired language disability, (3) delayed language acquisition (Developmental Language Disorder). Failure to acquire any language is rare and virtually always is a result of profound Mental Retardation. Acquired language disabilities are usually the result of trauma or neurological disorder. Developmental Language Disorder, the most common type of language disorder, involves difficulty in comprehending oral language (Receptive Type) or in expressing verbal language (Expressive Type). (Although these two subtypes are described separately, no digit is available for indicating them separately.)

These conditions have each been referred to as Developmental Aphasia, but this is technically not correct, since aphasia means loss of language that has already been acquired.

Developmental language disorder: expressive type

The essential feature is failure to develop vocal expression (encoding) of language while understanding or decoding skills remain relatively intact. Mothers will report that their children seem to understand language, but "can't get the words out." Articulation is generally immature, with the more difficult sounds, e.g., th, r, s, z, y, l, being omitted or other sounds substituted for them. The child's vocabulary is severely restricted; and even by four years of age, the child usually is unable to generate more than short phrases. Old words appear to be forgotten when new ones are learned. The child's use of various grammatical structures is considerably below age level.

Associated features. There may be slight lags in achieving developmental milestones. Learning may be impaired, particularly in tasks involving perceptual skills or skills in recognizing and reproducing symbols in the proper sequence.

Prevalence. Preliminary studies indicate that 1 in every 1,000 children may have this disorder.

Familial pattern. Developmental Articulation Disorder and other Specific Developmental Disorders are more common in family members of individuals with Developmental Language Disorder, Expressive Type, than in the general population.

Differential diagnosis. In **Developmental Language Disorder, Receptive Type,** comprehension of language is impaired, whereas in Developmental Language Disorder, Expressive Type, language comprehension is within normal limits. In **Developmental Articulation Disorder,** expressive language (vocabulary and grammar) is within normal limits, whereas in Developmental Language Disorder, Expressive Type, expressive language is impaired.

In **Mental Retardation,** there is general impairment in intellectual functioning, whereas in Developmental Language Disorder, Expressive Type, nonverbal intelligence is within normal limits. With a **hearing impairment,** a child does not have a normal audiogram and does not respond normally to sounds, whereas in Developmental Language Disorder, Expressive Type, audiogram and response to sounds are normal. In **Infantile Autism** and in **Childhood Onset Pervasive Developmental Disorder,** there is no "inner language," imaginary play, use of gestures, or warm social relationships, whereas these are all present in children with Developmental Language Disorder, Expressive Type.

In **acquired aphasia,** normal language is followed by onset of language disorder that may be associated with head trauma, seizures, or EEG abnormalities, whereas in Developmental Language Disorder, Expressive Type, normal language has not developed.

Diagnostic criteria for Developmental Language Disorder, Expressive Type

A. Failure to develop vocal expression (encoding) of language despite relatively intact comprehension of language.

B. Presence of inner language (the presence of age-appropriate concepts, such as understanding the purpose and use of a particular household object).

C. Not due to Mental Retardation, Childhood Onset Pervasive Developmental Disorder, hearing impairment, or trauma.

Developmental language disorder: receptive type

The essential feature is failure to develop comprehension (decoding) and vocal expression (encoding) of language. Deficits occur in sensory perception (recognition of auditory symbols [sounds] or visual symbols [pictures]), integration (ability to relate or manipulate auditory or visual symbols [e.g., recognizing that

a shoe and a sock are somehow related]), storage recall (ability to reproduce a sequence of auditory or visual stimuli some time after it has been presented), and "sequencing" (ability to recognize or reproduce sequences of symbols).

Associated features. A partial hearing defect for pure tones, resistance to auditory arousal, and inability to localize sound sources are common in this disorder. There often is a mild delay in the development of motor skills. Reading and spelling difficulties are invariably present. EEG abnormalities, usually bilateral, have been reported in some cases.

Prevalence. The rate of occurrence may be as high as 1 in 2,000.

Familial pattern. Seizures and all Specific Developmental Disorders, especially Developmental Reading Disorder, are apparently more common among family members of individuals with Developmental Language Disorder, Receptive Type than in the general population.

Differential diagnosis. In **Developmental Language Disorder, Expressive Type,** the child's comprehension of language is within normal limits for age level, whereas in Developmental Language Disorder, Receptive Type, language comprehension is below age level. In **Developmental Articulation Disorder,** both expression and comprehension of language are within normal limits for the child's age level, whereas in Developmental Language Disorder, Receptive Type, these are both impaired. In **Mental Retardation** there is general impairment in intellectual functioning, whereas in Developmental Language Disorder, Receptive Type, the child has at least normal nonverbal IQ. In **hearing impairment,** the child will have a history of responding only to very loud sounds, whereas in Developmental Language Disorder, Receptive Type, there may be a history of variable and inconsistent responses to sounds, the child often responding more to environmental sounds than to speech sounds. Abnormal audiometric test results occur in both hearing impairment and in Developmental Language Disorder, Receptive Type. In **Infantile Autism** and in **Childhood Onset Pervasive Developmental Disorder,** no efforts are made to communicate or watch faces, whereas in Developmental Language Disorder, Receptive Type, the children will make eye contact and will often try to communicate through gestures. In Infantile Autism, Childhood Onset Pervasive Developmental Disorder, and Developmental Language Disorder, Receptive Type, there are short auditory memory spans, auditory discrimination problems, and abnormalities of pitch and intonation.

In **acquired aphasia,** normal language is followed by a sudden onset of language problems, whereas in Developmental Language Disorder, Receptive Type, there is failure to develop language.

Diagnostic criteria for Developmental Language Disorder, Receptive Type

A. Failure to develop comprehension (decoding) and vocal expression (encoding) of language.

B. Not due to hearing impairment, trauma, Mental Retardation, or Childhood Onset Pervasive Developmental Disorder.

315.39 Developmental Articulation Disorder

The essential feature is failure to develop consistent articulations of the later-acquired speech sounds, such as r, sh, th, f, z, l, or ch. Omissions occur or substitutions are made for these sounds, giving the impression of "baby talk." Vocabulary and grammatical structures are within age norms. This disorder encompasses a range from the misarticulation of one sound (e.g., l or n as in "lalling") to mispronouncing several sounds (e.g., s, z, sh, ch as in "lisping").

Associated features. Mild reading difficulties may be present.

Prevalence and sex ratio. The disorder is present in about 6% of male and 3% of female school-aged children.

Familial pattern. The disorder is more common among family members than in the general population.

Differential diagnosis. In **Developmental Language Disorder, Mental Retardation, Infantile Autism,** and **Childhood Onset Pervasive Developmental Disorder,** language development is impaired, whereas in Developmental Articulation Disorder, language development is normal. In **hearing impairment,** audiometric testing will reveal an abnormality, whereas in Developmental Articulation Disorder, hearing will be normal. In **dysarthria** (abnormal articulation due to disorders of the oral speech mechanism or to neurological abnormalities), there may be problems with chewing or sucking, drooling, the rate of speech may be slowed down, and vowel sounds may be affected. None of these are present in Developmental Articulation Disorder.

Diagnostic criteria for Developmental Articulation Disorder

A. Failure to develop consistent articulations of the later-acquired speech sounds, such as r, sh, th, f, z, l, or ch.

B. Not due to Developmental Language Disorder, Mental Retardation, Childhood Onset Pervasive Developmental Disorder, or physical disorders.

315.50 Mixed Specific Developmental Disorder

This category should be used when there is more than one Specific Developmental Disorder, but none is predominant. It is common for a delay in the development of one skill (e.g., reading, arithmetic, or language) to be associated with delays in other skills. The Mixed Specific Developmental Disorder category should be used when the mixture of delayed skills is such that all skills are impaired to relatively the same degree. When the skills are impaired to varying

degrees, multiple diagnoses should be recorded, the skill most seriously impaired being recorded first.

315.90 Atypical Specific Developmental Disorder
This is a residual category for use when there is a Specific Developmental Disorder not covered by any of the previous specific categories.

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Organic Mental Disorders*

In DSM-III a distinction is made between organic *brain syndromes* and organic *mental disorders.* "Organic brain syndrome" is used to refer to a constellation of psychological or behavioral signs and symptoms without reference to etiology (e.g., Delirium, Dementia); "organic mental disorder" designates a particular organic brain syndrome in which the etiology is known or presumed (e.g., Alcohol Withdrawal Delirium, Multi-infarct Dementia).

By tradition, disorders that are related either to aging of the brain or to the ingestion of a substance are classified as mental disorders. For this reason Primary Degenerative Dementia, Multi-infarct Dementia, and the various Substance-induced Organic Mental Disorders are included in Section 1 of this chapter, beginning on page 124. Organic Mental Disorders whose etiology or pathophysiological process is either a diagnosis not included in the mental disorders section of ICD-9-CM or is unknown are in Section 2, page 162.

The essential feature of all these disorders is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. Organic Mental Disorders are diagnosed (*a*) by recognizing the presence of one of the Organic Brain Syndromes, as described below, and (*b*) by demonstrating, by means of the history, physical examination, or laboratory tests, the presence of a specific organic factor judged to be etiologically related to the abnormal mental state. Under certain circumstances, however, a reasonable inference of an organic factor can be made from the clinical features alone, in which case only step (*a*) may be necessary for diagnosis.

Organic Mental Disorders are a heterogeneous group; therefore, no single description can characterize them all. The differences in clinical presentation reflect differences in the localization, mode of onset, progression, duration, and nature of the underlying pathophysiological process.

Differentiation of Organic Mental Disorders as a separate class does not imply that nonorganic ("functional") mental disorders are somehow independent of brain processes. On the contrary, it is assumed that all psychological processes, normal and abnormal, depend on brain function. Limitations in our knowledge, however, sometimes make it impossible to determine whether a given mental disorder in a given individual should be considered an organic mental disorder (because it is due to brain dysfunction of *known* organic etiology) or whether it should be diagnosed as other than an Organic Mental Disorder (because it is more adequately accounted for as a response to psychological or social

*This chapter begins with a general description of Organic Mental Disorders as a broad category. It then describes ten specific Organic Brain Syndromes. Finally, each of the various Organic Mental Disorders is described.

factors [as in Adjustment Disorder] or because the presence of a specific organic factor has not been established [as in Schizophrenia]).

The organic factor responsible for an Organic Mental Disorder may be a primary disease of the brain or a systemic illness that secondarily affects the brain. It may also be a substance or toxic agent that is either currently disturbing brain function or has left some long-lasting effect. Withdrawal of a substance on which an individual has become physiologically dependent is another cause of Organic Mental Disorder.

The most common Organic Brain Syndromes are Delirium, Dementia, Intoxication, and Withdrawal. These syndromes display great variability among individuals and in the same individual over time. More than one Organic Brain Syndrome may be present in an individual simultaneously (e.g., Delirium superimposed upon Dementia), and one Organic Brain Syndrome may succeed another (e.g., thiamine-deficiency Delirium [Wernicke's encephalopathy] followed by Alcohol Amnestic Disorder [Korsakoff's disease]).

Associated features. A wide variety of different emotional, motivational, and behavioral abnormalities are associated with Organic Mental Disorders. It is often impossible to decide whether the symptoms are the direct result of damage to the brain or are a reaction to the cognitive deficits and other psychological changes that constitute the essential features of these disorders.

Severe emotional disturbances may accompany cognitive impairment in a person who views it as a loss, a serious threat to self-esteem, or both. Anxiety, depression, irritability, and shame of varying degrees of intensity may be present.

Compulsive individuals tend to be particularly intolerant of and disturbed by their reduced cognitive capacity or by perceptual abnormalities, such as hallucinations. They tend to react with a fear of loss of control. There may also be severe depression leading to suicidal attempts. Other individuals cope with memory and other cognitive deficits by marked orderliness, which helps them maintain some degree of control. Such people insist on keeping things in exactly the same places, keeping detailed notes and diaries to counteract forgetfulness, and avoiding situations in which their deficits could be exposed. Some people resort to circumstantiality and confabulation in an effort to conceal gaps in memory.

Paranoid attitudes and actual delusions may be exhibited by habitually suspicious individuals who feel threatened by their cognitive impairment. They may accuse others of maliciously misplacing or stealing their possessions. Irritability and outbursts of temper, sometimes with physical aggression, may occur. Some individuals are euphoric; others, apathetic.

Decreased control over sexual, aggressive, and acquisitive impulses may accompany cognitive impairment. Social judgment may be impaired and result in inappropriate behavior that provokes retaliation. Inappropriate sexual advances, exhibitionistic acts, stealing, ravenous eating, and other manifestations of faulty impulse control may be exhibited.

These associated features reflect the individual's personality, educational level, and interpersonal relations as well as the type and severity of the cogni-

tive impairment or abnormality. They are not necessarily correlated with the degree of cognitive impairment: a person with a relatively mild cognitive impairment may display conspicuous emotional and behavioral disturbance. Severe and widespread brain dysfunction, such as follows extensive neuronal destruction or metabolic dysfunction, may produce apathy, lethargy, incontinence of urine or feces, diminished psychomotor activity, somnolence, or blunting of affect.

Emotional and behavioral disturbances may result in social isolation, by withdrawal or ostracism; and this, in turn, tends to aggravate the cognitive disability.

Age at onset. Organic Mental Disorders may occur at any age. Delirium is most apt to occur at the extremes of the life cycle, while Dementia is most common in the elderly.

Course. Since Organic Mental Disorders encompass such a wide range of psychopathological syndromes and organic etiologies, no single course characterizes them all. Onset may be sudden, as in the case of Delirium associated with an acute infection or Dementia resulting from major head trauma, or it may be insidious, as in Primary Degenerative Dementia or the personality disturbance sometimes associated with temporal lobe epilepsy.

The course is also extremely variable. It may be steadily or irregularly progressive, episodic, static, or rapidly or gradually resolving. A major factor in determining the course is the nature of the underlying pathology. Metabolic disorders, substance intoxications and withdrawals, and systemic illnesses tend to cause temporary brain dysfunction, and may be followed by full recovery. Pathological processes causing structural damage to the brain are more likely to cause permanent residual impairment.

ORGANIC BRAIN SYNDROMES

The Organic Brain Syndromes can be grouped into six categories:

1. **Delirium and Dementia,** in which cognitive impairment is relatively global;

2. **Amnestic Syndrome and Organic Hallucinosis,*** in which relatively selective areas of cognition are impaired;

3. **Organic Delusional Syndrome* and Organic Affective Syndrome,*** which have features resembling Schizophrenic or Affective Disorders;

4. **Organic Personality Syndrome,*** in which the personality is affected;

5. **Intoxication and Withdrawal,** in which the disorder is associated with ingestion or reduction in use of a substance and does not meet the criteria for

* When the etiological agent is a substance, the term "Organic" is dropped and the name of the substance is substituted. For example, Organic Hallucinosis due to alcohol is called Alcohol Hallucinosis.

any of the previous syndromes (Strictly speaking, these two Organic Brain Syndromes are etiologically rather than descriptively defined.);

6. **Atypical or Mixed Organic Brain Syndrome**, which constitutes a residual category for any other Organic Brain Syndrome not classifiable as one of the previous syndromes.

(This manual does not divide the Organic Brain Syndromes into psychotic and nonpsychotic or acute and chronic [irreversible] forms, as have other classifications. Whereas these distinctions were made on the basis of severity, mode of onset, and presumptions concerning prognosis, the present classification is based on clinical symptoms alone. Delirium may, however, be said to be roughly equivalent to the DSM-I concept of acute brain syndrome, and Dementia, to that of chronic brain syndrome.)

Delirium

The essential feature is a clouded state of consciousness, that is, a reduction in the clarity of awareness of the environment. This is manifested by difficulty in sustaining attention to both external and internal stimuli, sensory misperception, and a disordered stream of thought. In addition, disturbances of sleep-wakefulness and psychomotor activity are present. The onset is relatively rapid, and the course typically fluctuates. The total duration is usually brief.

In DSM-I this syndrome was called "acute brain syndrome." It has also been termed "acute exogenous reaction type," "acute confusional state," "toxic psychosis," and "metabolic encephalopathy." Furthermore, some reserve the term "delirium" for a particular, agitated variety of confusional state with vivid visual hallucinations. In this manual, however, Delirium is intended to include the broad spectrum of clinical states having in common the essential features described above.

In Delirium there is difficulty shifting, focusing, and sustaining attention. The individual is easily distracted by irrelevant stimuli. It may be difficult, or impossible, to engage him or her in conversation because attention wanders.

Perceptual disturbances are common and result in various misinterpretations, illusions, and hallucinations. For example, the banging of a door may be mistaken for a pistol shot (misinterpretation); the folds of the bedclothes may appear to be animate objects (illusion); or the individual may "see" a group of people hovering over the bed when no one is actually there (hallucination). Although sensory misperceptions and hallucinations are most commonly visual, they may occur in other sensory modalities as well. Misperceptions range from simple and uniform to highly complex. There are often both a delusional conviction of the reality of hallucinations and an emotional and behavioral response in keeping with their content.

The individual with Delirium cannot maintain a coherent stream of thought. Thinking loses its usual clarity and direction toward a goal; it appears fragmented and disjointed. In mild Delirium, this may be manifested by acceleration or slowing of thought; in severe Delirium, thinking may be totally disorganized. This disturbance is reflected in speech that, in some cases, is limited and sparse, and in others, pressured and incoherent, with unpredictable switching

from subject to subject. It is also reflected in defective reasoning and impaired goal-directed behavior. Perseveration of speech and behavior may appear. Although other cognitive disturbances, particularly disorientation and memory impairment, are also present in Delirium, the person may be so inattentive and incoherent that these mental functions cannot be meaningfully assessed.

The sleep-wakefulness cycle is almost invariably disturbed. This frequently involves some depression in the level of consciousness, ranging from simple drowsiness, through increasing stages of torpor, to stupor or semicoma. On the other hand, some individuals with Delirium are hypervigilant and have difficulty in falling asleep. Fluctuations from hypersomnolence to insomnia and reversals of the customary sleep-waking cycle may also be present. Vivid dreams and nightmares are common, and may merge with hallucinations.

Psychomotor activity is also disturbed. Many individuals are restless and hyperactive. Groping or picking at the bedclothes, attempting to get out of bed, striking out at nonexistent objects, and sudden changes of position are manifestations of increased psychomotor activity. On the other hand, there may be decreased psychomotor activity, with sluggishness and even certain features resembling catatonic stupor. Psychomotor activity often shifts abruptly from one of these extremes to another.

Associated features. Emotional disturbances are very common and quite variable. They include anxiety, fear, depression, irritability, anger, euphoria, and apathy. Some individuals maintain the same emotional tone throughout the course of the Delirium whereas others experience rapid and unpredictable changes from one emotional state to another. Fear is very commonly experienced, sometimes as the result of threatening hallucinations or poorly systematized delusions. If fear is marked, the individual may attempt to flee his or her surroundings without regard to possible injury, or may attack those who are falsely viewed as threatening. Severely depressed feelings may also lead to self-destructive acts. Crying, calls for help, cursing, muttering, moaning, and other vocal productions, particularly prominent at night, are further manifestations of the disturbed emotional state of individuals with Delirium.

Neurological signs are comparatively uncommon in Delirium. An important exception, however, is the presence of abnormal movements. Various forms of tremor are frequently present. Asterixis, a peculiar flapping movement of the hyperextended hands, was originally described in hepatic encephalopathy, but may be found in other delirious states as well. Autonomic signs (tachycardia, sweating, flushed face, dilated pupils, and elevated blood pressure) commonly occur.

Other disorders of higher cortical function in Delirium include dysnomia (inability to name objects) and dysgraphia (impaired ability to write).

Age at onset. Delirium can occur at any age, but is especially common in children and after the age of 60.

Course. Delirium usually develops over a short period of time. Sometimes it begins quite abruptly, e.g., after a head injury or following a seizure. At other

times it is preceded, for hours or days, by certain prodromal symptoms. These include restlessness, difficulty in thinking clearly, hypersensitivity to auditory and visual stimuli, nocturnal insomnia, daytime hypersomnolence, vivid dreams, and nightmares. The slower evolution is more likely if systemic illness or metabolic imbalance underlies the Delirium.

Fluctuation in symptoms is one of the hallmarks of Delirium. Typically, the individual is worse during sleepless nights or in the dark. So-called "lucid intervals," periods during which he or she is more attentive and coherent, may occur at any time, but are most common in the morning. These fluctuations help distinguish Delirium from other brain syndromes.

The duration of an episode of Delirium is usually brief, about one week; it is rare for Delirium to persist for more than a month. If the underlying disorder is promptly corrected or is self-limited, recovery from Delirium may be complete. On the other hand, if the underlying disorder persists, the clinical syndrome of Delirium gradually shifts to some other, more stable, organic brain syndrome, or may cause death.

Complications. Injuries may be sustained from falling out of bed or attempting to flee frightening hallucinations. Agitation may interfere with proper medical management. If inadequately or belatedly treated, Delirium may lead to a Dementia or, more rarely, an Amnestic Syndrome or Organic Personality Syndrome.

Etiological factors. The causes of Delirium usually lie outside the nervous system and include: systemic infections; metabolic disorders such as hypoxia, hypercarbia, hypoglycemia, ionic imbalances, hepatic or renal disease, or thiamine deficiency; postoperative states; and substance intoxication and withdrawal. Delirium also occurs in hypertensive encephalopathy, following seizures, and on regaining consciousness after head trauma. Certain focal lesions of the right parietal lobe and inferomedial surface of the occipital lobe may present as Delirium.

Predisposing factors. The immature or senescent brain is more susceptible to the development of Delirium. Preexisting brain damage or a previous history of Delirium appears to increase the chances of an individual's developing this syndrome.

Differential diagnosis. Schizophrenia, Schizophreniform Disorder, and other psychotic disorders may also be marked by hallucinations, delusions, and disordered thinking and speech. In Delirium, however, these symptoms are extremely random and haphazard, without evidence of systematization. The course fluctuates, and there is evidence of a clouded state of consciousness with global cognitive impairment. Finally, in Delirium there is often a generalized slowing of background activity in the electroencephalogram, and the syndrome's cause is obviously organic.

Whereas **Dementia** involves a global cognitive deficit occurring in a normal state of consciousness, Delirium is basically a clouded state of consciousness.

Often, however, the two syndromes coexist in the same individual, and it may be difficult to decide how much of the clinical picture to ascribe to one syndrome and how much to the other. One cannot diagnose Dementia in the presence of significant Delirium, because the symptoms of Delirium interfere with the proper assessment of Dementia. Only a definite history of pre-existing Dementia allows one to decide that an individual with Delirium also has Dementia. When there is uncertainty as to whether the symptoms in a given individual are basically those of Delirium or Dementia, it is best to make a provisional diagnosis of Delirium. This should lead to a more active therapeutic approach, and with time the proper diagnosis will become apparent.

Factitious Disorder with Psychological Symptoms simulating an Organic Brain Syndrome might, under rare circumstances, present a problem in the differential diagnosis of Delirium. The individual with Factitious Disorder shows inconsistencies in tests of mental status. A normal electroencephalogram also helps to exclude Delirium.

Diagnostic criteria for Delirium

A. Clouding of consciousness (reduced clarity of awareness of the environment), with reduced capacity to shift, focus, and sustain attention to environmental stimuli.

B. At least two of the following:

(1) perceptual disturbance: misinterpretations, illusions, or hallucinations
(2) speech that is at times incoherent
(3) disturbance of sleep-wakefulness cycle, with insomnia or daytime drowsiness
(4) increased or decreased psychomotor activity

C. Disorientation and memory impairment (if testable).

D. Clinical features that develop over a short period of time (usually hours to days) and tend to fluctuate over the course of a day.

E. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor judged to be etiologically related to the disturbance.

Dementia

The essential feature is a loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning. The deficit is multifaceted and involves memory, judgment, abstract thought, and a variety of other higher cortical functions. Changes in personality and behavior also occur. The diagnosis is not made if these features are due to clouding of consciousness, as in Delirium. However, Delirium and Dementia may coexist.

As with all Organic Brain Syndromes, an underlying causative organic factor is always assumed. In certain clinical states, e.g., Primary Degenerative Dementia, however, it may be impossible to show a *specific* organic factor as the definitive cause of the disturbance. These conditions may nevertheless be diagnosed as Dementia if (*a*) the impairment is a multifaceted loss of intellectual ability, (*b*) there is no evidence for a diagnosis other than an Organic Mental Disorder, and (*c*) a diligent search has failed to reveal a specific organic etiologic factor.

In the past, the term Dementia often implied a progressive or irreversible course. The definition of Dementia in this manual, however, is based on clinical symptoms alone, and carries no connotation as to prognosis. Dementia may be progressive, static, or remitting. The reversibility of a Dementia is a function of the underlying pathology and of the availability and timely application of effective treatment.

Memory impairment is usually the most prominent symptom. In mild Dementia there is forgetfulness in daily life and a need to have statements repeated several times to facilitate remembering. On examination there may only be a certain hesitancy in response to questions. In more severe memory impairment, the individual may forget names, telephone numbers, directions, conversations, and events of the day. He or she may leave tasks unfinished because of forgetting to return after an interruption. This may cause a person to leave the water running in the sink or to neglect turning off the stove. In advanced forms of Dementia, memory impairment is often so severe that the person forgets the names of close relatives, his or her own occupation, schooling, birthday, or, occasionally, even his or her own name. Memory disturbance may be formally documented by demonstrating difficulty in learning new information (short-term memory deficit) and in recalling material that was known in the past (long-term memory deficit). The former is tested by asking the individual to memorize the names of several unrelated objects, or a brief sentence, and then to repeat them after a few minutes of distraction; the latter is tested by asking about events that happened in the past.

Impairment of abstract thinking takes many forms. The individual has trouble coping with novel tasks, especially if pressed for time. He or she may try to avoid situations and tasks that require the processing of new and complex information. This deficit is sometimes formally assessed by asking the individual to interpret proverbs or to perform such tasks as finding similarities or differences between related words. The individual with Dementia interprets proverbs concretely and has difficulty in finding similarities or differences.

Impaired judgment and impulse control are also commonly observed. Coarse language, inappropriate jokes, neglect of personal appearance and hygiene, and a general disregard for the conventional rules of social conduct are evidence of bad judgment and poor impulse control. A previously cautious businesswoman may embark on a reckless business venture. An elderly spinster may make sexual advances to strangers. A retiree may shoplift without considering the consequences. Marked impairment of judgment and impulse control is particularly characteristic of certain Dementias that affect primarily the frontal lobes.

Dementia also involves a variety of disturbances of higher cortical function.

Although language is unaffected by some neurological disorders that cause Dementia, in others it is abnormal. It may appear vague, stereotyped, and imprecise, with long circumlocutory phrases; or there may be specific signs of aphasia, such as difficulty naming objects. In severe forms of Dementia, the individual may be virtually mute. So-called "constructional ability" is nearly always disturbed, and can be demonstrated by having the individual copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs. Agnosias (failure to recognize or identify objects despite intact sensory function) and apraxias (inability to carry out motor activities despite intact comprehension and motor function) may also be present.

Personality change is almost invariably present in Dementia, and may involve either an alteration or an accentuation of premorbid traits. A common pattern is for a normally active individual to become increasingly apathetic and withdrawn. The range of social involvement narrows. The personality loses its sparkle, and the individual is described by others as "not himself (or herself)." Another pattern of change is for a previously neat and meticulous person to become slovenly and unconcerned about appearances. On the other hand, some individuals display an accentuation of preexisting compulsive, histrionic, impulsive, or paranoid traits. Irritability and cantankerousness are also common features of Dementia.

Associated features. When Dementia is mild and the individual has some grasp of his or her deteriorating faculties, he or she may react with marked anxiety or depression. Attempts to conceal or compensate for subjectively perceived intellectual deficits are very common. This may result in excessive orderliness, social withdrawal, or a tendency to relate events in excessive detail so as to avoid exposure of gaps in memory. Paranoid ideation may occasionally be quite marked and result in false accusations and verbal or physical attacks. The habitually jealous individual who develops a Dementia may develop the delusion of marital infidelity and actually assault his or her spouse.

Individuals with Dementia are especially vulnerable to physical and psychosocial stressors. For example, bereavement or retirement may considerably aggravate intellectual deficits.

Age at onset. Dementia is found predominantly in the elderly, although certain specific etiologic factors (see below) may cause Dementia at any age. The diagnosis of Dementia may be made at any time after the intellectual quotient is fairly stable (usually by age 3 or 4). Thus, if a child at age 4 developed a chronic neurological disorder that interfered with previously acquired functions so as to significantly lower intellectual and adaptive functioning, he or she would be considered to have both Dementia and Mental Retardation. In such a case both diagnoses should be made, Mental Retardation being listed first because of its greater relevance to management.

Course. The mode of onset and subsequent course of Dementia depend on the underlying etiology. When Dementia is a result of some clearly defined episode of neurological disease, such as cerebral hypoxia or encephalitis, or of head

trauma, it may begin quite suddenly, but then remain relatively stationary for a long period of time. Primary Degenerative Dementia, on the other hand, is usually insidious in onset and slowly, but relentlessly, progresses to death over a period of several years. Dementia resulting from brain tumors, subdural hematomas, and metabolic factors may also have a gradual onset. When the underlying disorder can be treated, as in hypothyroidism, subdural hematoma, normal-pressure hydrocephalus, and tertiary neurosyphilis, Dementia may be arrested or even reversed. However, the more widespread the structural damage to the brain, the less likely is clinical improvement.

Impairment. By definition Dementia is diagnosed only when the loss of intellectual function is sufficiently severe to interfere with social or occupational functioning, although the degree of impairment may vary. In advanced Dementia the individual becomes totally oblivious of his or her surroundings and requires constant care.

Complications. Individuals with Dementia may wander and become lost. They may, occasionally, do harm to themselves or others. Delirium frequently is a complication of Dementia. Individuals with severe Dementia are susceptible to infectious diseases, which often prove fatal.

Etiological factors. Primary Degenerative Dementia of the Alzheimer type is the most common Dementia. Other causes include: central nervous system infections (including tertiary neurosyphilis, tuberculous and fungal meningitis, viral encephalitis, and Jakob-Creutzfeldt disease); brain trauma (especially chronic subdural hematoma); toxic-metabolic disturbances (such as pernicious anemia, folic-acid deficiency, hypothyroidism, bromide intoxication); vascular disease (Multi-infarct Dementia); normal-pressure hydrocephalus; neurological diseases such as Huntington's chorea, multiple sclerosis, and Parkinson's disease; and postanoxic or posthypoglycemic states.

Differential diagnosis. The **normal process of aging** has been associated in a number of studies with a variety of different changes in intellectual function. The nature of these changes and whether they should be considered true decrements of function, however, remain controversial. The diagnosis of Dementia is warranted only if intellectual deterioration is of sufficient severity to interfere with social or occupational functioning. Dementia is not synonymous with aging.

In **Delirium** there is also impairment of intellectual abilities, but it occurs in the context of clouding of consciousness; in Dementia the state of consciousness is normal. The clinical course of these two syndromes also differs. In Delirium symptoms typically fluctuate, whereas in Dementia they are relatively stable. An Organic Mental Disorder persisting in unchanged form for more than a few months suggests Dementia rather than Delirium. (See also Delirium, Differential diagnosis, p. 106.)

Schizophrenia, especially when chronic, may be associated with some degree of intellectual deterioration. The absence of identifiable brain pathology helps rule out the additional diagnosis of Dementia.

Individuals with a **major depressive episode** may complain of memory impairment, difficulty in thinking and concentrating, and an overall reduction in intellectual abilities. They may also perform poorly on mental-status examination and neuropsychological testing. These features may suggest the possible diagnosis of Dementia, and this phenomenon is sometimes known as "pseudodementia." Depression, however, is primarily a disturbance of mood. Any cognitive deficits observed may be viewed as secondary to the disturbed affect. If sufficiently motivated to perform, individuals with depression usually demonstrate intact cognitive function. Dementia, on the other hand, is basically a disorder of intellectual function. Abnormalities of mood are less frequent and, when present, less pervasive than in depression. The clinical history also helps to differentiate between the two. In depressive pseudodementia, the onset can frequently be dated with some precision, and symptoms progress more rapidly than in true Dementia. In addition, there may be a history of previous mental illness. On formal mental-status testing there may be considerable variability in performance as opposed to the more consistently poor performance of individuals with Dementia. In the absence of evidence of a specific organic etiologic factor, if the features suggesting major depressive episode are at least as prominent as those suggesting Dementia, it is best to diagnose major depressive episode and to assume that the features suggesting Dementia are secondary to the depression. A therapeutic trial with an antidepressant drug or electroconvulsive therapy (ECT) (if not contraindicated) may clarify the diagnosis in that if the disorder is actually a major depressive episode, cognitive impairment may resolve as the mood improves.

Factitious Disorder with Psychological Symptoms may mimic Dementia, but rarely.

Diagnostic criteria for Dementia

A. A loss of intellectual abilities of sufficient severity to interfere with social or occupational functioning.

B. Memory impairment.

C. At least one of the following:

(1) impairment of abstract thinking, as manifested by concrete interpretation of proverbs, inability to find similarities and differences between related words, difficulty in defining words and concepts, and other similar tasks

(2) impaired judgment

(3) other disturbances of higher cortical function, such as aphasia (disorder of language due to brain dysfunction), apraxia (inability to carry out motor activities despite intact comprehension and motor function), agnosia (failure to recognize or identify objects despite intact sensory function), "constructional difficulty" (e.g., inability to

copy three-dimensional figures, assemble blocks, or arrange sticks in specific designs)

(4) personality change, i.e., alteration or accentuation of premorbid traits

D. State of consciousness not clouded (i.e., does not meet the criteria for Delirium or Intoxication, although these may be superimposed).

E. Either (1) or (2):

(1) evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance

(2) in the absence of such evidence, an organic factor necessary for the development of the syndrome can be presumed if conditions other than Organic Mental Disorders have been reasonably excluded and if the behavioral change represents cognitive impairment in a variety of areas

Amnestic Syndrome

The essential feature is impairment in short- and long-term memory occurring in a normal state of consciousness (i.e., not clouded). The disturbance is attributed to a specific organic factor. Amnestic Syndrome is not diagnosed if memory impairment exists in the context of clouded consciousness (Delirium) or in association with a more general loss of intellectual abilities (Dementia).

The individual with an Amnestic Syndrome has both an ongoing inability to learn new material (short-term memory deficit; anterograde amnesia) and an inability to recall material that was known in the past (long-term memory deficit; retrograde amnesia). The former is conventionally assessed by requiring the individual to remember several unrelated words or a short paragraph after a brief (usually 5-15-minute) interval of distraction. The latter is tested by asking questions about events of the past such as birthplace, family, schooling, vocation, major historical events, the names of recent presidents, etc. The individual with an Amnestic Syndrome has difficulty with both of these operations of memory. Events of the very remote past, however, are often better recalled than more recent events. For example, an individual may remember in vivid detail a hospital stay that took place a decade before examination, but may have no idea that he or she is currently in the hospital. So-called "immediate memory" (e.g., digit span), however, is *not* impaired in Amnestic Syndrome.

Associated features. A significant degree of amnesia nearly always results in disorientation. Confabulation, the recitation of imaginary events to fill in gaps in memory, is often observed, and when present tends to disappear with time. Most individuals with this syndrome lack insight into their memory deficit, and may explicitly deny it, despite evidence to the contrary. Others acknowledge a problem, but appear unconcerned. Apathy, lack of initiative, and emotional

blandness are common. Although the individual is superficially friendly and agreeable, his or her affect is shallow.

When Amnestic Syndrome is the result of Alcohol Dependence and vitamin deficiency (see Alcohol Amnestic Disorder, p. 136), other neurological complications of alcohol ingestion and malnutrition, such as peripheral neuropathy, cerebellar ataxia, etc., may also be observed.

Course. The mode of onset depends on the etiology. In most cases it is fairly sudden. The subsequent course, also a function of the etiology, is usually one of chronicity.

Impairment. Impairment in social and occupational functioning is usually moderate to severe.

Complications. Any complications are the direct result of the individual's memory impairment. For example, the individual's forgetting to extinguish a lighted cigarette may cause a fire.

Etiological factors. Amnestic Syndrome may result from any pathological process that causes bilateral damage to certain diencephalic and medial temporal structures (e.g., mammillary bodies, fornix, hippocampal complex). Examples include head trauma, surgical intervention, hypoxia, infarction in the territory of the posterior cerebral arteries, and herpes simplex encephalitis. The most common form of Amnestic Syndrome is that associated with thiamine deficiency and chronic use of alcohol.

Prevalence. The syndrome is apparently uncommon.

Differential diagnosis. Delirium and **Dementia** also involve memory impairment. In Delirium, however, there is also a clouding of consciousness; and in Dementia, there are other major intellectual deficits as well.

In **Factitious Disorder with Psychological Symptoms,** memory testing often yields inconsistent results. Furthermore, there is no organic etiologic factor.

Diagnostic criteria for Amnestic Syndrome

A. Both short-term memory impairment (inability to learn new information) and long-term memory impairment (inability to remember information that was known in the past) are the predominant clinical features.

B. No clouding of consciousness, as in Delirium and Intoxication, or general loss of major intellectual abilities, as in Dementia.

C. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

Organic Delusional Syndrome

The essential feature is the presence of delusions that occur in a normal state of consciousness and that are due to a specific organic factor. The diagnosis is not made if delusions occur in a clouded state of consciousness, as in Delirium, if there is a significant loss of intellectual abilities, as in Dementia, or prominent hallucinations are present, as in Organic Hallucinosis.

The nature of the delusions is variable and depends, to some extent, on the etiology. Persecutory delusions are the most common type. Amphetamine use may cause a highly organized paranoid delusional state indistinguishable from the active phase of Schizophrenia. Some individuals with cerebral lesions develop the delusion that a limb of their body is missing.

Hallucinations may be present in an Organic Delusional Syndrome, but they are not the predominant feature.

Associated features. Mild cognitive impairment is often observed. As in Schizophrenia, almost any symptom may occur as an associated feature. The individual may appear perplexed, disheveled, or eccentrically dressed. Speech may be rambling or incoherent. Abnormalities of psychomotor activity may occur, with either hyperactivity (pacing, rocking), or apathetic immobility. Ritualistic, stereotyped behavior, sometimes associated with magical thinking, may also be observed. A dysphoric mood is common.

Impairment. Impairment in social and occupational functioning is usually severe.

Complications. The individual may harm himself or herself or others while reacting to delusions.

Etiological factors. These are diverse. A number of substances—e.g., amphetamines, cannabis, and hallucinogens—may cause this syndrome. Some individuals with temporal lobe epilepsy have an interictal Organic Delusional Syndrome that is almost indistinguishable from Schizophrenia. A paranoid Organic Delusional Syndrome has been described in some cases of Huntington's chorea. Certain cerebral lesions, particularly of the nondominant hemisphere, result in this syndrome.

Certain substances can also cause a more or less permanent Organic Delusional Syndrome, essentially identical with Schizophrenia, even after the substance is no longer present in the body, analogous to "flashback" hallucinations.

Differential diagnosis. Nonorganic psychotic disorders such as **Schizophrenia** or **Paranoid Disorders** must be distinguished from Organic Delusional Syndrome. Differentiation rests primarily on evidence, gathered from the history, physical examination, or laboratory tests, of a specific organic factor judged to be responsible for the development of the delusions. The appearance of delusions *de novo* in an individual over the age of 30 years without a known history of Schizophrenia or Paranoid Disorder should always alert the diagnostician to the possibility of an Organic Delusional Syndrome. On the other hand, the fact

that an individual has a prior history of nonorganic psychosis does not mean that one should neglect consideration of an Organic Delusional Syndrome, especially if there is concern about a possible organic factor (for example, the ingestion of an hallucinogen).

In **Organic Hallucinosis,** hallucinations are the predominant feature. Delusions, if present, are related to the hallucinations. In **Organic Affective Syndrome,** symptoms resembling those of the Affective Disorders predominate. Delusions and hallucinations, if present, have a content related to the mood disturbance.

Diagnostic criteria for Organic Delusional Syndrome

A. Delusions are the predominant clinical feature.

B. There is no clouding of consciousness, as in Delirium; there is no significant loss of intellectual abilities, as in Dementia; there are no prominent hallucinations, as in Organic Hallucinosis.

C. There is evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

Organic Hallucinosis

The essential feature is the presence of persistent or recurrent hallucinations that occur in a normal state of consciousness and that are attributable to a specific organic factor. Therefore, the diagnosis is not made if hallucinations occur in a clouded state of consciousness, as in Delirium, with significant loss of intellectual abilities, as in Dementia, if there is a major disturbance of mood, as in Organic Affective Syndrome, or if delusions predominate, as in Organic Delusional Syndrome.

Hallucinations may occur in any modality, but certain organic factors tend to produce hallucinations of a particular type. For example, hallucinogens most commonly cause visual hallucinations, whereas alcohol tends to induce auditory hallucinations. Individuals who are blind as a result of cataracts may develop visual hallucinations; those who are deaf as a result of otosclerosis will have auditory hallucinations. Hallucinations vary from very simple and unformed to highly complex and organized.

The individual may be aware that the hallucinations are not real, or may have a firm delusional conviction of their reality. Delusions, however, are not the major feature of this syndrome, and are restricted to the content of the hallucinations or to the belief that the hallucinations are real. Further elaboration of delusional material (for example, the development of systematized persecutory delusions to account for the hallucinations, or delusions not related to the hallucinations) suggests an Organic Delusional Syndrome.

Associated features. These features vary according to the etiology, the en-

vironment, and individual differences in response. Hallucinosis in congenial surroundings may be a pleasant experience; in other circumstances, the hallucinations may be fraught with anxiety, depression, or other dysphoric affects.

Course. Course depends on the underlying etiology. Alcohol Hallucinosis may last for as brief a period as a few hours to as long as several years. Untreated cataracts or otosclerosis may cause a chronic Hallucinosis. If the syndrome is the result of sensory deprivation, the duration may be quite brief.

Impairment. The degree of impairment is primarily a function of the underlying etiology.

Complications. Accidents may occur in attempting to flee from frightening hallucinations.

Etiological factors. Use of hallucinogens and prolonged use of alcohol are the most common causes of this syndrome. Sensory deprivation, as in blindness or deafness, is another cause. Seizure foci, especially in the temporal and occipital lobes, may also cause the syndrome.

Differential diagnosis. In **Delirium,** hallucinations, if present, occur with clouding of consciousness. In **Dementia,** hallucinations, if present, are associated with a general loss of intellectual abilities. In **Organic Delusional Syndrome,** hallucinations, if present, are overshadowed by the prominent delusions.

Schizophrenia and **Affective Disorders** may involve hallucinations, but no specific organic factor can be demonstrated.

Hypnogogic and **hypnopompic hallucinations** may occur in individuals without a mental disorder, but they occur only on falling asleep or on awakening.

Diagnostic criteria for Organic Hallucinosis

A. Persistent or recurrent hallucinations are the predominant clinical feature.

B. No clouding of consciousness, as in Delirium; no significant loss of intellectual abilities, as in Dementia; no predominant disturbance of mood, as in Organic Affective Syndrome; no predominant delusions, as in Organic Delusional Syndrome.

C. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

Organic Affective Syndrome

The essential feature is a disturbance in mood, resembling either a manic episode or a major depressive episode, that is due to a specific organic factor. The diagnosis is not made if the disturbance in mood occurs in a clouded state of consciousness, as in Delirium; if it is accompanied by a significant loss of intellectual abilities, as in Dementia, or persistent or recurrent hallucinations, as in Organic Hallucinosis; or if delusions predominate, as in Organic Delusional Syndrome.

The clinical phenomenology of this syndrome is the same as that of a manic or major depressive episode (p. 206 and p. 210). The severity of the disturbance may range from mild to severe. If delusions or hallucinations are present, they are similar to those described under Affective Disorders.

Associated features. Mild cognitive impairment is often observed. Any of the features associated with the Affective Disorders may also be present. If the mood is depressed, these features may include fearfulness, anxiety, irritability, brooding, excessive somatic concerns, phobias, panic attacks, suspiciousness, and a tearful, sad appearance. Delusions of persecution or worthlessness can occur. If the mood is manic, irritability and lability of mood may be present. Hallucinations and delusions are more common in the manic form than in the depressed form.

Impairment. Minimal to severe impairment can result.

Complications. See manic and major depressive episodes (p. 216).

Etiological factors. This syndrome is usually caused by toxic or metabolic factors. Certain substances, notably reserpine, methyldopa, and some of the hallucinogens, are apt to cause a depressive syndrome. Endocrine disorders are another important etiological factor, and may produce either depressive or manic syndromes. Examples are hyper- and hypothyroidism and hyper- and hypoadrenocorticalism. Carcinoma of the pancreas is sometimes associated with the depressive syndrome, possibly due to an endocrine disturbance. Viral illness may also cause a depressive syndrome. Structural disease of the brain is a rare cause of an Organic Affective Syndrome.

Differential diagnosis. In **Affective Disorders,** no specific organic factor can be demonstrated. When an affective episode follows the taking of a psychoactive substance, such as reserpine, the causal relationship between the ingestion of the substance and the affective disturbance may not be clear. A history of previous Affective Disorder in the individual or in family members suggests that the substance merely triggered an Affective Disorder in an individual who was particularly vulnerable to the organic factor. On the other hand, the absence of a history of previous Affective Disorder in the individual or family members suggests an Organic Affective Syndrome.

In **Organic Personality Syndrome,** there may be a disturbance of mood, but it is not as prominent as the change in personality.

Diagnostic criteria for Organic Affective Syndrome

A. The predominant disturbance is a disturbance in mood, with at least two of the associated symptoms listed in criterion B for manic or major depressive episode (see p. 208 and p. 213).

B. No clouding of consciousness, as in Delirium; no significant loss of intellectual abilities, as in Dementia; no predominant delusions or hallucinations, as in Organic Delusional Syndrome or Organic Hallucinosis.

C. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

Organic Personality Syndrome

The essential feature is a marked change in personality that is due to a specific organic factor but that is not due to any other Organic Brain Syndrome. Organic Personality Syndrome in a young child may occur before the development of an enduring style of relating to the environment (personality). In such cases, the syndrome is recognized by significant changes in the child's usual behavior patterns.

The clinical syndrome in a given individual depends principally on the nature and localization of the pathological process. A common pattern is characterized by emotional lability and impairment in impulse control or social judgment. The individual may be belligerent or have temper outbursts and sudden bouts of crying with little or no provocation. Socially inappropriate actions, such as sexual indiscretions, may be engaged in with little concern for the consequences. Another pattern is characterized by marked apathy and indifference. The individual may have no interest in his or her usual hobbies and appear unconcerned with events occurring in the immediate environment. (Both of these patterns may be associated with damage to the frontal lobes, and for this reason are sometimes referred to as "frontal lobe syndromes.") Another recognized pattern, seen in some individuals with temporal lobe epilepsy, is a marked tendency to humorless verbosity in both writing and speech, religiosity, and, occasionally, exaggerated aggressiveness.

The major personality change may be the development of suspiciousness or paranoid ideation.

Associated features. Mild cognitive impairment and irritability may be present.

Course. The course depends on the etiology. It may be transient, if it is the result of a medication or other substance use, or persistent, if it is secondary to

structural damage to the brain. Occasionally an Organic Personality Syndrome is the first manifestation of a disease process that eventually causes a Dementia. For example, in multiple sclerosis an Organic Personality Syndrome may precede the eventual development of a Dementia.

Impairment. The degree of impairment is variable. Despite relatively intact cognitive function, poor judgment may lead to such difficulties that the person may require constant supervision or even custodial care.

Complications. Socially unacceptable behavior may lead to social ostracism or legal difficulties. Impulsive or explosive behavior may be dangerous to the individual and to others.

Etiological factors. Organic Personality Syndrome is usually due to structural damage to the brain. The most common causes are neoplasms (for example, meningiomas pressing on the frontal lobes), head trauma (including the post-concussion syndrome), and vascular disease. A characteristic Organic Personality Syndrome has been described as an interictal phenomenon in some individuals with temporal lobe epilepsy. Multiple sclerosis and Huntington's chorea are sometimes associated with this syndrome. Rather uncommon causes are endocrine disorders (thyroid and adrenocortical disease) and the ingestion of certain substances.

Differential diagnosis. In **Dementia,** personality change is but one facet of an overall syndrome that also includes significant loss of intellectual abilities. Occasionally, personality change may be the first sign of an organic brain syndrome that will eventually evolve into Dementia. In these instances the initial diagnosis of Organic Personality Syndrome will have to be changed to Dementia as intellectual deficits increase and become the predominant feature. In **Organic Affective Syndrome** there may be a personality change, but a mood disturbance is the predominant clinical feature.

When **Attention Deficit Disorder** develops in a child or adolescent and is due to a specific organic factor, such as a known neurological disease, the additional diagnosis of Organic Personality Syndrome should not be made if the disturbance is limited to an impairment of impulse control and attention.

In **Schizophrenia, Paranoid Disorders, Affective Disorders,** and **Disorders of Impulse Control Not Elsewhere Classified,** marked personality changes may occur. In these disorders, however, no specific organic factor is judged etiologically related to the personality change.

Diagnostic criteria for Organic Personality Syndrome

A. A marked change in behavior or personality involving at least one of the following:

(1) emotional lability, e.g., explosive temper outbursts, sudden crying

(2) impairment in impulse control, e.g., poor social judgment, sexual indiscretions, shoplifting
(3) marked apathy and indifference, e.g., no interest in usual hobbies
(4) suspiciousness or paranoid ideation

B. No clouding of consciousness, as in Delirium; no significant loss of intellectual abilities, as in Dementia; no predominant disturbance of mood, as in Organic Affective Syndrome; no predominant delusions or hallucinations, as in Organic Delusional Syndrome or Organic Hallucinosis.

C. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

D. This diagnosis is not given to a child or adolescent if the clinical picture is limited to the features that characterize Attention Deficit Disorder (see p. 41).

Intoxication

The essential features are maladaptive behavior and a substance-specific syndrome that are due to the recent use and presence in the body of a substance. Evidence for the recent use and presence in the body of the substance can be obtained by history, physical examination (e.g., smell of alcohol), or laboratory tests of urine or blood. The clinical picture does not correspond to any of the specific Organic Brain Syndromes, such as Delirium, Organic Delusional Syndrome, Organic Hallucinosis, or Organic Affective Syndrome. (Intoxication may, however, be superimposed on any Organic Brain Syndrome, with the exception of Delirium.)

As used here, the concept of Intoxication is a residual category for a clinical picture, caused by an exogenous substance, that does not correspond to any of the specific Organic Brain Syndromes. Thus, use of amphetamine that caused clouding of consciousness and tactile hallucinations would be diagnosed as Amphetamine Delirium, and only the milder clinical picture, without the full symptomatic picture of Delirium, would be diagnosed as Amphetamine Intoxication. Similar states caused by endogenous substances (such as ketone bodies in diabetic acidosis) should be coded in the category Atypical or Mixed Organic Brain Syndrome (see p. 162).

Although the specific clinical picture is determined by the nature of the substance used, the most common changes involve disturbances of perception, wakefulness, attention, thinking, judgment, emotional control, and psychomotor behavior.

As used here, Intoxication refers to a mental disorder and requires the presence of maladaptive behavior. It should be noted that when used in the physiological sense, the term "intoxication" is broader in scope than this definition

implies. Therefore, recreational use of substances that causes physiological and psychological changes but that does not result in maladaptive behavior is not considered Intoxication. For example, social drinking frequently causes loquacity, euphoria, and slurred speech; but this should not be considered Intoxication unless maladaptive behavior, such as fighting, impaired judgment, interference with social functioning, poor job performance, or failure to meet responsibilities, results.

Associated features. The particular substance used, the individual's expectations, pre-intoxication personality and biological state, and the environmental circumstances of the substance use determine the associated features. For example, Cannabis Intoxication may be intensified in an individual expecting religious revelations from the substance. Intoxication in public places may result in belligerent behavior or accidents. Withdrawn individuals may use intoxication as a method of achieving further social withdrawal (as in the "solitary drinker"). Individuals with depression may become suicidal or experience increased dysphoria when intoxicated.

Course. The rapidity of onset and the duration of an Intoxication depend on: the amount of the substance consumed, how rapidly it was consumed, the individual's tolerance (innate or acquired), body size (in general, the larger the person, the larger the quantity required to induce intoxication), and the half-life of the particular substance. In the case of alcohol, other considerations are the specific beverage consumed (distilled spirits produce higher blood levels than the same amount of alcohol consumed in the same period in the form of beer or wine) and whether the alcohol is combined with food.

Intoxication usually lasts for a few hours, but may last several days. In rare instances an individual may continue taking the substance so that he or she remains intoxicated for even longer periods.

Impairment. During the intoxicated state the individual has, by definition, some impairment in social or occupational functioning. This impairment in ability to function may be only minimal—for example, in Cannabis Intoxication at a time when the individual knows that he or she has no social or occupational responsibilities. On the other hand, impairment may be marked, for example, in Alcohol Intoxication, if the intoxication occurs when the individual has major social or occupational responsibilities.

Complications. Excessive ingestion of substances that have a depressant effect on the nervous system may result in coma or death. Substances that act as stimulants may cause seizures. During the intoxicated state the individual may fall or become involved in an automobile accident.

An individual who has repeated instances of Intoxication over a period of one month also has, by definition, Substance Abuse or Dependence. For some of the substances, an initial Intoxication may develop into a specific Organic Brain Syndrome. For example, Amphetamine Intoxication may develop into Amphetamine Delirium; or methyl alcohol Intoxication may lead to a Dementia.

Differential diagnosis. When the criteria for **Delirium, Organic Hallucinosis, Organic Delusional Syndrome** or **Organic Affective Syndrome** are met following the ingestion of a substance, these conditions are diagnosed, because Intoxication is a residual category.

Many **neurological diseases** can produce symptoms, such as slurred speech and incoordination, that resemble an Intoxication.

Diagnostic criteria for Intoxication

A. Development of a substance-specific syndrome that follows the recent ingestion and presence in the body of a substance.

B. Maladaptive behavior during the waking state due to the effect of the substance on the central nervous system, e.g., impaired judgment, belligerence.

C. The clinical picture does not correspond to any of the specific Organic Brain Syndromes, such as Delirium, Organic Delusional Syndrome, Organic Hallucinosis, or Organic Affective Syndrome.

Withdrawal

The essential feature is the development of a substance-specific syndrome that follows the cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiological state of intoxication.* Evidence for the cessation or reduction of regular use of a substance may be obtained by history or by laboratory tests of urine or blood. The clinical picture does not correspond to any of the specific Organic Brain Syndromes, such as Delirium, Organic Hallucinosis, Organic Delusional Syndrome, and Organic Affective Syndrome. (Withdrawal may, however, be superimposed on any Organic Brain Syndrome with the exception of Delirium.)

As used here, the concept of Withdrawal is a residual category for a clinical picture caused by cessation of or reduction in intake of a substance that does not correspond to any of the specific Organic Brain Syndromes. Thus, a clinical syndrome of clouding of consciousness and tactile hallucinations following cessation of alcohol use is diagnosed as Alcohol Withdrawal Delirium, and only the milder clinical picture associated with cessation of alcohol use is termed Alcohol Withdrawal.

The syndrome that develops varies according to the substance the individual was using. Common symptoms include anxiety, restlessness, irritability, insomnia, and impaired attention.

Associated features. The nature of the substance determines the associated features, which may range from disturbing physiological symptoms, such as nausea and vomiting following cessation of heavy alcohol intake, to diffuse ma-

* Strictly speaking, in the case of the fetal alcohol syndrome, it is the mother, and not the infant, who has ingested the substance for the purpose of inducing intoxication.

laise, such as that following chronic use of certain sedatives, or compelling desire to resume taking the substance. There may be changes in sleep patterns and mood, as can be seen after withdrawal from amphetamines or corticosteroids, or convulsions after Barbiturate Withdrawal.

Course. Withdrawal is usually self-limited to no more than a few days or, at most, several weeks, except when complicated by the development of a specific Organic Brain Syndrome, such as a Delirium.

Impairment. Impairment varies from mild, as in Tobacco Withdrawal, to severe, as may be the case in Alcohol or Opioid Withdrawal.

Complications. In order to avoid painful withdrawal symptoms, the individual may continue to use the substance. Illegal behavior, such as stealing to pay for heroin, may result from efforts to obtain the substance.

Differential diagnosis. Many **physical disorders** have symptoms that are similar to the symptoms of Withdrawal. For example, the symptoms of influenza are very similar to the symptoms of Opioid Withdrawal.

Diagnostic criteria for Withdrawal

A. Development of a substance-specific syndrome that follows the cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a state of intoxication.

B. The clinical picture does not correspond to any of the specific Organic Brain Syndromes, such as Delirium, Organic Delusional Syndrome, Organic Hallucinosis, or Organic Affective Syndrome.

Atypical or mixed organic brain syndrome

This is a residual category reserved for syndromes that do not meet the criteria for any of the other Organic Brain Syndromes and in which there are maladaptive changes during the waking state with evidence, from either physical examination, laboratory tests, or history, of a specific organic factor that is judged to be etiologically related to the disturbance. An example would be the "neurasthenic" picture associated with early Addison's Disease.

This category should also be used when the individual has an Organic Brain Syndrome with features of more than one syndrome but not enough of any one to meet the criteria for a single syndrome.

Diagnostic criteria for Atypical or Mixed Organic Brain Syndrome

A. The disturbance occurs during the waking state and does not fulfill the criteria for any of the previously described Organic Brain Syndromes.

B. Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance.

ORGANIC MENTAL DISORDERS—SECTION 1

Organic Mental Disorders in which the etiology or pathophysiological process is listed below (taken from the mental disorders section of ICD-9-CM).

This section consists of two groups of disorders of organic etiology that are traditionally classified as mental disorders: the first category includes Dementias due to certain neurological diseases characteristically appearing in the senium and presenium; the second is composed of Substance-induced Organic Mental Disorders.

DEMENTIAS ARISING IN THE SENIUM AND PRESENIUM

The Dementias associated with Alzheimer's and Pick's diseases have been referred to as Senile and Presenile Dementias, the former arbitrarily signifying an age at onset over 65. Since nearly all cases of these Dementias are associated with Alzheimer's disease and the identification of Alzheimer's and Pick's diseases is largely or entirely dependent on histopathological data, it seems more useful to have in a clinical classification of mental disorders a single category that encompasses the syndrome of Primary Degenerative Dementia. This category is subtyped according to the age at onset, for the purpose of historical continuity and to maintain comparability with ICD-9-CM. The clinician will rarely be in a position to identify the specific associated neurological disorder. When such information is available, it should be noted on Axis III.

In DSM-II, the Dementia associated with vascular disease was called Psychosis with Cerebral Arteriosclerosis. However, the severity of the disorder appears to be related to repeated infarcts of the brain rather than to the extent of cerebral arteriosclerosis. At autopsy the brain shows multiple infarcts of various ages. For this reason, this category is here termed Multi-infarct Dementia.

When a Dementia is due to some other known disease, such as a brain tumor, Huntington's chorea, or vitamin B-12 deficiency, the specific disease should be noted on Axis III, and the presence of a Dementia, on Axis I (294.10 Dementia, from Section 2 of this chapter, p. 162).

290.xx Primary Degenerative Dementia

The essential feature is the presence of Dementia of insidious onset and gradually progressive course for which all other specific causes have been excluded by the history, physical examination, and laboratory tests. The Dementia involves a multifaceted loss of intellectual abilities, such as memory, judgment, abstract thought, and other higher cortical functions, and changes in personality and behavior. (See p. 107 for a description of the essential and associated features of Dementia.)

Phenomenological subtypes. Frequently the clinical picture may be compli-

cated by the presence of significant depressive features or of delusions, usually persecutory. More rarely there may be a superimposed Delirium. These additional features, when present, should be noted with the appropriate codes (p. 126).

Age at onset. Senile onset (after age 65) is much more common than presenile onset. Few cases develop before the age of 49.

Course. The onset is insidious, and the course is one of uniform, gradual progression. In the early stages memory impairment may be the only apparent cognitive deficit. There may also be subtle personality changes, such as the development of apathy, lack of spontaneity, and a quiet withdrawal from social interactions. Individuals usually remain neat and well-groomed and, aside from an occasional irritable outburst, are cooperative and behave in a socially appropriate way. With progression to the middle stage of the disease, various cognitive disturbances become quite apparent, and behavior and personality are more obviously affected. By the late stage, the individual may be completely mute and inattentive. At this point he or she is totally incapable of caring for himself or herself. This stage leads inevitably to death. With senile onset, the average duration of symptoms, from onset to death, is about five years.

Impairment and complications. See Dementia, p. 110.

Pathology. In the majority of cases, the brain is atrophied, with widened cortical sulci and enlarged cerebral ventricles. This may be demonstrated in life by computer-assisted tomography or pneumoencephalography. Microscopic examination usually reveals three histopathological changes: senile plaques, neurofibrillary tangles, and granulovacuolar degeneration of neurons. These are the changes classically described in Alzheimer's disease. Rare cases have the histological features of Pick's disease, mixed vascular and degenerative disease, or nonspecific pathological changes.

Predisposing factors. Down's syndrome predisposes to Alzheimer's disease.

Prevalence. Between 2% and 4% of the population over the age of 65 is estimated to have Primary Degenerative Dementia. The prevalence increases with increasing age, particularly after 75.

Sex ratio. The disorder is more common in women than in men.

Familial pattern. First-degree relatives are four times more likely to develop the disease than members of the general population. In rare cases, Primary Degenerative Dementia of the Alzheimer's type is inherited as a dominant trait.

Differential diagnosis. The normal process of aging has been associated in a number of studies with certain decrements in intellectual functioning. The nature and significance of these changes are controversial. The diagnosis of Pri-

mary Degenerative Dementia should be limited to cases in which there is clear evidence of progressive and significant deterioration of intellectual and social or occupational functioning. (See Dementia, differential diagnosis, p. 110, for discussion.)

Subdural hematoma, normal-pressure hydrocephalus, cerebral neoplasm, Parkinson's disease, vitamin B_{12} deficiency, hypothyroidism, substance intoxication, and other specific and possibly treatable physical disorders that may cause Dementia need to be ruled out by the history, physical examination, and appropriate laboratory tests.

In **Multi-infarct Dementia** the clinical course is more variable and typically progresses in stepwise fashion with focal neurological signs and systemic evidence of vascular disease. In occasional cases, the two disorders may coexist, and both diagnoses should be recorded.

Elderly individuals with a major depressive episode may have features strongly suggesting Dementia. For a discussion of this important problem in differential diagnosis, see **major depressive episode** (p. 212) and **Dementia** (p. 111).

Subtypes

Primary Degenerative Dementia, Senile Onset (after age 65)

290.30 with delirium

290.20 with delusions

290.21 with depression

290.00 uncomplicated

Primary Degenerative Dementia, Presenile Onset (age 65 and below)

290.11 with delirium

290.12 with delusions

290.13 with depression

290.10 uncomplicated

Diagnostic criteria for Primary Degenerative Dementia

A. Dementia (see p. 111).

B. Insidious onset with uniformly progressive deteriorating course.

C. Exclusion of all other specific causes of Dementia by the history, physical examination, and laboratory tests.

290.4x Multi-infarct Dementia

The essential feature of this Dementia is a stepwise deterioration in intellectual functioning that early in the course leaves some intellectual functions relatively intact ("patchy" deterioration).

Focal neurological signs and symptoms are also present, and there is evidence of significant cerebrovascular disease that is judged to be etiologically related to the disturbance.

The onset is typically abrupt; and the course is stepwise and fluctuating, with rapid changes, rather than uniformly progressive. The pattern of deficits is "patchy," depending upon which regions of the brain have been destroyed. Certain cognitive functions may be affected early while others remain relatively unimpaired. The Dementia typically involves disturbances in memory, abstract thinking, judgment, impulse control, and personality. See Dementia, p. 107.

The focal neurological signs commonly seen include weaknesses in the limbs, reflex asymmetries, extensor plantar responses, dysarthria, and small stepped gait.

Vascular disease is always presumed to be present and responsible for both the Dementia and the focal neurological signs. Evidence of cerebral and systemic vascular disease may be apparent on physical examination. Frequently there will be hypertension, carotid bruit, funduscopic abnormalities, or an enlarged heart. These conditions should be noted on Axis III.

Associated features. Pseudobulbar palsy, with fleeting episodes of laughing and crying (sham emotion), dysarthria, and dysphagia is very common. There may be periods of increased confusion, possibly related to further vascular insults.

Age at onset. The onset of Multi-infarct Dementia is apparently earlier than that of Primary Degenerative Dementia.

Course. As noted above, the course is erratic. Early treatment of hypertension and vascular disease may prevent further progression.

Pathology. The brain shows multiple and extensive localized areas of softening. There may also be a variety of pathological changes in the cerebral vessels.

Predisposing factors. The most significant factor is arterial hypertension. Extracranial vascular disease of the great vessels in the neck and valvular disease of the heart may be sources of cerebral emboli.

Prevalence. Multi-infarct Dementia is apparently much less common than Primary Degenerative Dementia.

Sex ratio. The disorder is apparently more common in men.

Familial pattern. No information.

Differential diagnosis. A **single stroke** may cause a relatively circumscribed change in the mental state, such as an aphasia following damage to the left hemisphere, or an Amnestic Syndrome from infarction in the region of the posterior cerebral arteries. As a general rule, a single stroke does not cause Dementia. Multi-infarct Dementia results from the occurrence of multiple strokes, at different times.

In **Primary Degenerative Dementia** the course is uniformly progressive rather than stepwise as in Multi-infarct Dementia, and there is usually no evidence of cerebrovascular disease. In some instances both Multi-infarct Dementia and Primary Degenerative Dementia may coexist, with clinical features of both entities. In such cases both diagnoses should be recorded.

Subtypes

Multi-infarct Dementia

290.41 with delirium

290.42 with delusions

290.43 with depression

290.40 uncomplicated

Diagnostic criteria for Multi-infarct Dementia

A. Dementia (see p. 111).

B. Stepwise deteriorating course (i.e., not uniformly progressive) with "patchy" distribution of deficits (i.e., affecting some functions, but not others) early in the course.

C. Focal neurological signs and symptoms (e.g., exaggeration of deep tendon reflexes, extensor plantar response, pseudobulbar palsy, gait abnormalities, weakness of an extremity, etc.).

D. Evidence, from the history, physical examination, or laboratory tests, of significant cerebrovascular disease that is judged to be etiologically related to the disturbance.

SUBSTANCE-INDUCED ORGANIC MENTAL DISORDERS*

This section of the classification deals with the various Organic Brain Syndromes caused by the direct effects on the nervous system of various substances. They are distinguished from the Substance Use Disorders that refer to the behavior associated with taking substances that affect the central nervous system.

* In order for the DSM-III classification to be compatible with ICD-9-CM, some diagnoses in this subclass share the same code number. Non-ICD-9-CM codes are provided in parentheses in the classification (Chapter 1) for use when greater specificity is necessary.

In most cases the diagnosis of these Organic Mental Disorders will be made in individuals who also have a Substance Use Disorder.

This section includes those Substance-induced Organic Mental Disorders caused by the ten classes of substances that most commonly are taken nonmedicinally to alter mood or behavior: alcohol, barbiturates or similarly acting sedatives or hypnotics, opioids, cocaine, amphetamines or similarly acting sympathomimetics, phencyclidine (PCP) or similarly acting arylcyclohexylamines, hallucinogens, cannabis, tobacco, and caffeine. Although some of these substances also have a legitimate medicinal purpose, they may under unsupervised circumstances cause Organic Mental Disorders. In addition, there is a residual class for Organic Mental Disorders caused by other or unknown substances.

For each class of substances, the specific disorders described represent the types of Organic Brain Syndrome known to be caused by that class of substance. For example, whereas alcohol causes many different syndromes, the current evidence suggests that cocaine causes only one.

The descriptions of these disorders often do not include many categories of information, such as age at onset, predisposing factors, prevalence, and sex ratio. This information is frequently available in the corresponding portion of the Substance Use Disorder section. The description of Impairment for each of the individual Organic Brain Syndromes can be found in the preceding section. For many of the Substance-induced Organic Mental Disorders, a predisposing factor is prolonged heavy use with the development of dependence. Since this is obvious, only other predisposing factors are noted, when known.

Recording specific diagnoses. Whenever possible the clinician should record the name of the specific substance rather than the name of the entire class of substances, using the code number for the appropriate class. Examples: the clinician should write 305.70 Amphetamine Intoxication (rather than Amphetamine or Similarly Acting Sympathomimetic Intoxication); 292.00 Valium Withdrawal (rather than Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal); 292.81 Atropine Delirium (rather than Other or Unspecified Substance Delirium).

ALCOHOL ORGANIC MENTAL DISORDERS

This section includes the following Organic Mental Disorders attributed to the ingestion of alcohol: Alcohol Intoxication, Alcohol Idiosyncratic Intoxication, Alcohol Withdrawal, Alcohol Withdrawal Delirium, Alcohol Hallucinosis, Alcohol Amnestic Disorder and Dementia Associated with Alcoholism.

Although ICD-9-CM has a category for Alcoholic Jealousy, the literature does not provide sufficient evidence to support the existence of this syndrome as an independent entity. The concept "alcoholic jealousy" can be expressed in DSM-III terms by a diagnosis of Alcohol Dependence and an additional diagnosis of a Paranoid Disorder.

303.00 Alcohol Intoxication

The essential feature is maladaptive behavior due to the recent ingestion of

alcohol. This may include aggressiveness, impaired judgment, and other manifestations of impaired social or occupational functioning. Characteristic physiological signs include flushed face, slurred speech, unsteady gait, nystagmus, and incoordination. Characteristic psychological signs include loquacity, impaired attention, irritability, euphoria, depression, and emotional lability.

The diagnosis is not made when there is evidence that the amount of alcohol ingested was insufficient to cause intoxication in most people, as in Alcohol Idiosyncratic Intoxication (p. 132).

Associated features. The individual's usual behavior may be accentuated or altered. For example, an individual who tends to be somewhat suspicious may, under the influence of alcohol, become markedly paranoid. On the other hand, individuals who are ordinarily withdrawn and uncomfortable in social situations may become exceptionally convivial.

Alcohol Intoxication is sometimes associated with an amnesia for the events that occurred during the course of the intoxication ("blackouts").

Course. Although alcohol is basically a central nervous system depressant, its initial behavioral effects are often viewed as "disinhibitory" phenomena. Thus, early in the course of Alcohol Intoxication, an individual may appear exceptionally bright, expansive, and hyperactive, with a subjective sensation of well-being and increased mental sharpness. With further intoxication, however, the individual may slow down and become depressed, withdrawn, and dull, and even lose consciousness.

The duration of an episode of Alcohol Intoxication depends on a variety of factors, including the amount and type of alcoholic beverage consumed, how rapidly it was ingested, and whether or not it was taken with food. Since only a small percentage of alcohol is excreted, the rate at which alcohol is metabolized—approximately 5-10 ml per hour—plays a very important role in determining the length of a period of intoxication. The development of short-term tolerance may also influence the course of Alcohol Intoxication so that a person may appear less intoxicated after many hours of drinking than after a few hours. There is considerable individual variation in susceptibility to intoxication with alcohol. Some individuals show intoxication with blood alcohol levels as low as 30 mg % whereas others appear unintoxicated with levels as high as 150 mg %.

The signs of intoxication are more marked when the blood alcohol level is rising than when it is falling. Most individuals become intoxicated at blood alcohol levels between 100 and 200 mg %. Death has been reported with levels ranging from 400 to 700 mg %. Alcohol exerts its fatal effect either by a direct depression of respiration or by aspiration of vomitus.

Complications. Highway accidents are a major complication of Alcohol Intoxication. At least half of all highway fatalities involve either a driver or a pedestrian who has been drinking. Intoxication also results in falls and numerous household and industrial accidents. Moreover, it is frequently associated with the commission of criminal acts. More than one-half of all murderers and their victims are believed to be intoxicated at the time of the act. One study in-

dicates that about one-fourth of all suicides occur while the individual is drinking alcohol.

Alcohol Intoxication frequently results in physical disorders. Falls and accidents result in fractures, subdural hematomas, and other forms of brain trauma. Exposure to extreme weather leads to frostbite and sunburn. Alcohol Intoxication may also possibly suppress immune mechanisms and thus predispose to infections.

Differential diagnosis. Social drinking is associated with physiological intoxication. Maladaptive behavior is required for the mental disorder Alcohol Intoxication to be diagnosed.

Intoxication due to barbiturates and similarly acting sedatives and hypnotics has the same clinical picture as Alcohol Intoxication. Since an individual may be taking both alcohol and other substances, the presence of alcohol on the breath does not exclude the possibility that another substance is responsible for the intoxication.

Certain neurological diseases, such as **cerebellar ataxias** or **multiple sclerosis,** may have some of the physiological signs and symptoms of Alcohol Intoxication.

In **Alcohol Idiosyncratic Intoxication,** a marked change in behavior follows ingestion of an amount of alcohol that is insufficient to cause Alcohol Intoxication in most individuals.

Diagnostic criteria for Alcohol Intoxication

A. Recent ingestion of alcohol (with no evidence suggesting that the amount was insufficient to cause intoxication in most people).

B. Maladaptive behavioral effects, e.g., fighting, impaired judgment, interference with social or occupational functioning.

C. At least one of the following physiological signs:

(1) slurred speech
(2) incoordination
(3) unsteady gait
(4) nystagmus
(5) flushed face

D. At least one of the following psychological signs:

(1) mood change
(2) irritability
(3) loquacity
(4) impaired attention

E. Not due to any other physical or mental disorder.

291.40 Alcohol Idiosyncratic Intoxication

The essential feature is a marked behavioral change—usually to aggressiveness—that is due to the recent ingestion of an amount of alcohol insufficient to induce intoxication in most people. There is usually subsequent amnesia for the period of intoxication. The behavior is atypical of the person when not drinking—for example, a shy, retiring, mild-mannered person may, after one weak drink, become belligerent and assaultive. During the episode the individual seems out of contact with others.

This disorder has also been called "Pathological Intoxication."

Age at onset. No information.

Course. The change in behavior begins either while the individual is drinking or shortly thereafter. The duration is quite brief, and the condition ceases within a few hours. The individual returns to his or her normal state as the blood alcohol level falls.

Prevalence. Apparently extremely rare.

Complications. The individual may do harm to himself or herself or to others.

Predisposing factors. A small percentage of individuals with this disorder have been reported to have temporal lobe spikes on an electroencephalogram after receiving small amounts of alcohol. Although the reports are still anecdotal, it is thought that people with brain damage lose "tolerance" for alcohol and behave abnormally after drinking small amounts. The types of brain injury most often associated with this syndrome are from trauma and encephalitis. The loss of tolerance may be temporary or permanent. It is also reported that individuals who are unusually fatigued or have a debilitating physical illness may have a low tolerance for alcohol and respond inappropriately to small amounts.

Differential diagnosis. Other exogenous agents, especially **barbiturates and similarly acting substances,** may occasionally cause abrupt changes in behavior. **Temporal lobe epilepsy,** during the interictal period, may be associated with fits of destructive rage. **In Malingering,** the individual may wish to avoid responsibility for aggressive behavior, claiming that it occurred while he or she was intoxicated from a small amount of alcohol.

Diagnostic criteria for Alcohol Idiosyncratic Intoxication

A. Marked behavioral change, e.g., aggressive or assaultive behavior that is due to the recent ingestion of an amount of alcohol insufficient to induce intoxication in most people.

B. The behavior is atypical of the person when not drinking.

C. Not due to any other physical or mental disorder.

291.80 Alcohol Withdrawal

The essential features are certain characteristic symptoms such as a coarse tremor of the hands, tongue, and eyelids, nausea and vomiting, malaise or weakness, autonomic hyperactivity (such as tachycardia, sweating, and elevated blood pressure), anxiety, depressed mood or irritability, and orthostatic hypotension, that follow within several hours cessation of or reduction in alcohol ingestion by an individual who has been drinking alcohol for several days or longer. The diagnosis is not made if the disturbance is Alcohol Withdrawal Delirium.

Associated features. Headache and dry mouth, not necessarily due to dehydration, are frequent symptoms. The complexion is often puffy and blotchy, and there may be mild peripheral edema. When nausea and vomiting are present, there may also be gastritis.

Sleep is often fitful and disturbed by "bad dreams." These merge with a variety of misperceptions and illusions. Brief, poorly formed hallucinations, occurring in any modality of sensation, may be experienced.

Age at onset. Most individuals with Alcohol Dependence begin drinking early in life and develop their first withdrawal symptoms in their 30s or 40s.

Course. Withdrawal symptoms begin shortly after cessation of or reduction in drinking and almost always disappear within five to seven days, unless Alcohol Withdrawal Delirium develops.

Complications. Major motor seizures ("rum fits") may occur. Individuals with a preexisting history of epilepsy are more apt to develop withdrawal seizures.

Predisposing factors. Malnutrition, fatigue, depression, and concomitant physical illness may aggravate the syndrome.

Differential diagnosis. In **Alcohol Withdrawal Delirium** there are a clouded state of consciousness and other symptoms characteristic of Delirium.

In **Alcohol Hallucinosis** the hallucinations are prominent and persistent whereas if they occur in Alcohol Withdrawal, they are brief and poorly formed.

Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal produces a syndrome essentially identical with that of Alcohol Withdrawal. **Hypoglycemia,** whether or not related to alcohol, and **diabetic ketoacidosis** result in symptoms similar to those of Alcohol Withdrawal. **Essential tremor** may suggest the tremulousness of Alcohol Withdrawal.

Diagnostic criteria for Alcohol Withdrawal

A. Cessation of or reduction in heavy prolonged (several days or longer) ingestion of alcohol, followed within several hours by coarse tremor of hands, tongue, and eyelids and at least one of the following:

(1) nausea and vomiting
(2) malaise or weakness
(3) autonomic hyperactivity, e.g., tachycardia, sweating, elevated blood pressure
(4) anxiety
(5) depressed mood or irritability
(6) orthostatic hypotension

B. Not due to any other physical or mental disorder such as Alcohol Withdrawal Delirium.

291.00 Alcohol Withdrawal Delirium

The essential feature is a Delirium (p. 104) that is due to recent cessation of or reduction in alcohol consumption. Autonomic hyperactivity, such as tachycardia and sweating, and elevated blood pressure, is present. Delusions, vivid hallucinations, and agitated behavior usually occur. Hallucinations, when present, are usually visual, but may occur in other sensory modalities.

This disorder has been called "delirium tremens."

Associated features. A coarse, irregular tremor is almost always present. Fever may also occur.

Age at onset. The first episode of this disorder usually occurs after 5 to 15 years of heavy drinking, usually episodic. For this reason, the disorder usually first occurs in the person's 30s or 40s.

Course. The onset is usually on the second or third day after the cessation of or reduction in drinking. Occasionally it occurs earlier; it rarely appears more than a week after abstinence. Unless complicated by some other illness, the syndrome most often runs its course in two to three days. If seizures also occur as the result of Alcohol Withdrawal ("rum fits"), they always precede the development of Delirium.

Complications. See Delirium (p. 106).

Predisposing factors. The presence of a concomitant physical illness may predispose to this syndrome.

Prevalence. This syndrome is much less common than Alcohol Withdrawal. In one study, no more than 5% of patients admitted to a general hospital for Alcohol Dependence had Alcohol Withdrawal Delirium.

Differential diagnosis. See Delirium (p. 106).

Diagnostic criteria for Alcohol Withdrawal Delirium

A. Delirium (p. 107) occurs within one week after cessation of or reduction in heavy alcohol ingestion.

B. Autonomic hyperactivity, e.g., tachycardia, sweating, elevated blood pressure.

C. Not due to any other physical or mental disorder.

291.30 Alcohol Hallucinosis

The essential feature is an Organic Hallucinosis (see p. 115) with vivid auditory hallucinations following cessation of or reduction in alcohol ingestion by an individual who apparently has Alcohol Dependence. The hallucinations are usually voices, and less commonly unformed sounds such as hissing or buzzing. Onset may accompany a gradual decrease in blood alcohol levels toward the end of an extended period of Intoxication; but it most often occurs soon after cessation of drinking, usually within the first 48 hours, although occasionally somewhat later.

In the majority of cases, the content of the hallucinations is unpleasant and disturbing. However, the hallucinatory content may be benign, leaving the individual undisturbed. The voices may address the individual directly, but more often they discuss him or her in the third person. When the voices are threatening, the individual may act to defend himself or herself by calling on the police for protection, or arming against invaders. The actions of the individual are practically never the result of the hallucinations' commanding the individual to act in a certain way, but rather are motivated by the desire to avoid disgrace, injury, or other consequences of what the voices threaten.

Associated features. Other signs of withdrawal following prolonged intoxication may occur, such as transient visual hallucinations, tremulousness, seizures, and, in some cases, Delirium.

Age at onset. Although first episodes have been reported in people in their early to mid-20s, the more typical onset is about age 40, and follows 10 years or more of heavy drinking.

Course. Most frequently the disorder lasts only a few hours or days, typically, less than a week. In about 10% of cases, however, it may last several weeks or months; in a few cases, a chronic form develops.

With the evolution of the chronic form, which may be recognized as early as a week after the onset of the illness, the individual becomes quiet and resigned despite the fact that the hallucinations remain threatening and derogatory. Ideas of reference and other poorly systematized persecutory delusions become prominent. At this stage the illness may be clinically indistinguishable from Schizophrenia, with vague and illogical thinking, tangential associations, and inappropriate affect. There is some evidence that the chronic form is more likely to develop from repeated episodes of the disorder.

Impairment. Impairment may be severe, as the individual responds to the hallucinations as though they were real.

Complications. In an effort to avoid the consequences of threatening voices, the individual may harm himself or herself or others.

Predisposing factors. This disorder occurs only following prolonged, heavy ingestion of alcohol in individuals who apparently have Alcohol Dependence. Contrary to previously held beliefs, there is no evidence that Schizophrenia predisposes to the development of this disorder.

Prevalence. Apparently rare.

Sex ratio. The disorder is apparently four times more common in males than in females.

Familial pattern. No information.

Differential diagnosis. In Schizophrenia there is no temporal relation of psychotic symptoms to the cessation of alcohol use and there is a chronic course. Moreover, the age at onset of Alcohol Hallucinosis is later than in Schizophrenia, and both the family background and pre-illness personalities are not typical of those for Schizophrenia.

Diagnostic criteria for Alcohol Hallucinosis

A. Organic Hallucinosis (see p. 116) with vivid auditory hallucinations developing shortly (usually within 48 hours) after cessation of or reduction in heavy ingestion of alcohol in an individual who apparently has Alcohol Dependence.

B. Response to the hallucinations appropriate to their content, e.g., anxiety in response to hallucinatory threats.

C. No clouding of consciousness, as in Delirium.

D. Not due to any other physical or mental disorder.

291.10 Alcohol Amnestic Disorder

The essential feature is an Amnestic Syndrome (see p. 112) due to the vitamin deficiency associated with prolonged, heavy use of alcohol. Alcohol Amnestic Disorder due to thiamine deficiency is also known as Korsakoff's Disease.

Associated features. Neurological disturbances such as peripheral neuropathy, cerebellar ataxia, or myopathy are among the associated features.

Course. Alcohol Amnestic Disorder often follows an acute episode of Wernicke's encephalopathy, a neurological disease manifested by confusion, ataxia, eye-movement abnormalities (gaze palsies, nystagmus), and other neurological signs. Gradually these manifestations subside, but a major impairment of memory, Alcohol Amnestic Disorder, remains. If Wernicke's disease is treated early with large doses of thiamine, Alcohol Amnestic Disorder may not develop.

Once Alcohol Amnestic Disorder becomes established, it usually persists indefinitely. A slight degree of improvement over a long period of time may occur.

Impairment. Impairment is usually quite severe, and life-long custodial care may be necessary.

Complications. See Amnestic Syndrome, p. 113.

Predisposing factors. Alcohol Dependence (by definition).

Prevalence. The disorder is apparently rare, perhaps because of the routine administration of thiamine during detoxification.

Differential diagnosis. In **Dementia Associated with Alcoholism** the disturbance is not limited to memory impairment.

See Amnestic Syndrome, p. 113.

Diagnostic criteria for Alcohol Amnestic Disorder

A. Amnestic Syndrome (see p. 113) following prolonged heavy ingestion of alcohol.

B. Not due to any other physical or mental disorder.

291.2x Dementia Associated with Alcoholism

The essential feature is a Dementia (see p. 107) associated with prolonged and heavy ingestion of alcohol for which all other causes of Dementia have been excluded. In order to exclude transient effects of Intoxication and Withdrawal, this diagnosis should not be made until at least three weeks have elapsed since the cessation of alcohol use.

The etiologic role of alcohol in the Dementia associated with prolonged heavy ingestion of alcohol is controversial.

Subtyping. The severity of the Dementia is noted in the fifth digit (see below). The severe form corresponds to what was called Alcoholic Deterioration in DSM-II. Both the severe and the mild forms of this entity have been described by various studies in the literature. What has been termed "moderate" represents a theoretical intermediate stage. It is not established whether these forms repre-

sent different points along a continuum, or whether the mild and the severe forms have different pathophysiologies.

Associated features. See Alcohol Dependence (p. 169) and Dementia (p. 109).

Age at onset. This syndrome rarely begins before the age of 35 since many years of heavy drinking are apparently necessary to produce Dementia.

Course. No information.

Impairment. Mild cognitive deficits demonstrable only by psychological testing have been reported in some individuals with Alcoholism. As this diagnosis involves a Dementia, by definition there is always some impairment in social or occupational functioning. When impairment is severe, the individual becomes totally oblivious of his or her surroundings and requires constant care.

Complications. See Dementia, p. 110.

Predisposing factors. Alcohol Dependence (by definition).

Prevalence. Mild, sometimes reversible, intellectual impairment is commonly found when a specific search is made in individuals with chronic Alcohol Dependence. The severe form of this disorder is apparently rare.

Differential diagnosis. Dementia Associated with Alcoholism is distinguished from **Alcohol Amnestic Disorder** by the presence of cognitive deficits other than in the sphere of memory alone. It is distinguished from **other causes of Dementia** by the failure to demonstrate a specific etiology other than alcohol abuse. For the differential diagnosis of Dementia, see p. 110.

Diagnostic criteria for Dementia Associated with Alcoholism

A. Dementia (see p. 111) following prolonged, heavy ingestion of alcohol.

B. Dementia persisting at least three weeks after cessation of alcohol ingestion.

C. Exclusion of all other causes of Dementia, other than prolonged, heavy use of alcohol, by the history, physical examination, and laboratory tests.

Severity criteria for the Dementia

291.21 Mild

No more than mild impairment in social and occupational functioning.

291.22 Moderate
Moderate social impairment with inability to function occupationally.

291.23 Severe
Severe impairment of functioning with marked deterioration of personality (irritability, social inappropriateness) and inability to function independently.

291.20 Unspecified

BARBITURATE OR SIMILARLY ACTING SEDATIVE OR HYPNOTIC ORGANIC MENTAL DISORDERS

Included in this classification are disorders induced by barbiturates and similarly acting sedatives and hypnotics.

The common minor tranquilizers are the benzodiazepines, such as chlordiazepoxide, diazepam, and oxazepam. Common hypnotics include ethchlorvynol, flurazepam, glutethimide, methyprylon, chloral hydrate, paraldehyde, and methaqualone.

Although these substances differ widely in their rates of absorption, metabolism, distribution in the body, and likelihood of producing intoxication and withdrawal, at some dose and at some duration of use they are all capable of producing signs and symptoms of intoxication and withdrawal that are essentially the same as those produced by the barbiturates. For this reason the barbiturates are the prototype for this group of substances.

Substances in this class are usually taken orally in the form of pills or capsules.

Because of the great pharmacological differences in the substances covered in this section and of the wide individual variation in responses to them, specific doses for specific withdrawal syndromes are not listed.

305.40 Barbiturate or Similarly Acting Sedative or Hypnotic Intoxication
The essential and associated features are virtually identical with those of Alcohol Intoxication (see p. 129). The only exception is that there is no syndrome of Idiosyncratic Intoxication. Differences that may occur between Alcohol Intoxication and Intoxication by this class of substances are most likely due to differences in the personalities of the individuals who become intoxicated and in the settings in which the intoxications occur. For example, the settings in which Alcohol Intoxication is apt to occur probably account for the greater likelihood that it will be accompanied by displays of aggression or violence, compared with intoxication by this class of substances.

Course. As with Alcohol Intoxication, the initial behavioral effects are usually disinhibitory. If the individual continues to ingest the substance, inhibitory effects will supervene.

The factors involved in rapidity of onset and duration of the intoxication are discussed in the text on Intoxication as an Organic Brain Syndrome (see p. 121).

Complications. All of the complications noted for Alcohol Intoxication may occur with this class of substances, although they are less commonly seen. From initiation of regular barbiturate use to the development of physical dependence, the margin between the intoxicating dose and the lethal dose progressively narrows as the dose necessary for intoxication increases. The upper limit for the lethal dose usually does not exceed 3.5 to 4.0 grams. Therefore, a fatal overdose can be ingested accidentally. Unlike with Alcohol Intoxication, death is a more frequent complication because the individual is able to take enough of the substance over a short period of time to induce marked depression of central nervous system function.

Differential diagnosis. Other substances causing intoxication must be considered. Although breath odor may be an important differentiating clue with alcohol and many inhalants, it should not be absolutely relied upon.

Parenteral administration of naloxone or other opioid antagonists will alleviate the symptoms of **Opioid Intoxication,** but will have no effect on intoxications due to other substances.

Reliable qualitative and quantitative tests for the presence in the blood and urine of barbiturates and some of the other substances in this class may be useful.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Intoxication

A. Recent use of a barbiturate or similarly acting sedative or hypnotic.

B. At least one of the following psychological signs:

(1) mood lability
(2) disinhibition of sexual and aggressive impulses
(3) irritability
(4) loquacity

C. At least one of the following neurological signs:

(1) slurred speech
(2) incoordination
(3) unsteady gait
(4) impairment in attention or memory

D. Maladaptive behavioral effects, e.g., impaired judgment, interference with social or occupational functioning, failure to meet responsibilities.

E. Not due to any other physical or mental disorder.

292.00 Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal

The essential features are virtually identical with those of Alcohol Withdrawal (see p. 133). The only exception is that a coarse tremor is not invariably present.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal

A. Prolonged, heavy use of barbiturate or similarly acting sedative or hypnotic, or more prolonged use of smaller doses of a benzodiazepine.

B. At least three of the following due to recent cessation of or reduction in substance use:

(1) nausea and vomiting
(2) malaise or weakness
(3) autonomic hyperactivity, e.g., tachycardia, sweating, elevated blood pressure
(4) anxiety
(5) depressed mood or irritability
(6) orthostatic hypotension
(7) coarse tremor of hands, tongue, and eyelids

C. Not due to any other physical or mental disorder, such as Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal Delirium.

292.00 Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal Delirium

The essential feature is a Delirium (see p. 104) occurring within one week after cessation of or reduction in heavy use of a barbiturate or similarly acting sedative or hypnotic. All of the features are virtually identical with those of Alcohol Withdrawal Delirium (see p. 134), but the disorder is apparently not as common.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal Delirium

A. Delirium (see p. 107) within one week after cessation of or reduction in heavy use of a barbiturate or similarly acting sedative or hypnotic.

B. Autonomic hyperactivity, e.g., tachycardia, sweating, elevated blood pressure.

C. Not due to any other physical or mental disorder.

292.83 Barbiturate or Similarly Acting Sedative or Hypnotic Amnestic Disorder

The essential feature is an Amnestic Syndrome (see p. 112) due to prolonged heavy use of a barbiturate or similarly acting sedative or hypnotic.

Age at onset. There is some evidence that the age at onset is in the 20s. The earlier onset compared with that of Alcohol Amnestic Disorder may be due to the more common earlier age at onset of heavy use of this class of substances compared with alcohol.

Course. The course is variable. Unlike Alcohol Amnestic Disorder, full recovery may occur.

Impairment, complications, and differential diagnosis. See Amnestic Syndrome, p. 113.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Amnestic Disorder

A. Prolonged, heavy use of a barbiturate or similarly acting sedative or hypnotic.

B. Amnestic Syndrome (see p. 113).

C. Not due to any other physical or mental disorder.

OPIOID ORGANIC MENTAL DISORDERS

This group includes natural opioids, such as heroin and morphine, and synthetics with morphine-like action, such as meperidine and methadone. These substances are taken either orally, intravenously, intranasally, or subcutaneously ("skin popping").

Although methadone is included in this class, individuals properly supervised in a methadone maintenance program should not develop any of the Opioid Organic Mental Disorders. When they do meet the criteria for this diagnosis, this indicates that there has been nonmedical use of methadone, in which case the appropriate diagnosis should be made.

305.50 Opioid Intoxication

The essential features are specific neurological and psychological signs and maladaptive behavioral effects due to the recent use of an opioid.

Psychological signs commonly present include euphoria or dysphoria, apathy, and psychomotor retardation.

Pupillary constriction is always present (or dilation due to anoxia from a severe overdose). Other neurological signs commonly observed are drowsiness, slurred speech, and impairment in attention and memory.

The maladaptive behavioral effects may include impaired judgment, interference with social or occupational functioning, and failure to meet responsibilities.

Associated features. Pupillary constriction may lead to reduced visual acuity. The inhibitory effect of the substance on gastrointestinal motility may cause constipation. There may be analgesia.

For many individuals, the effect of taking an opioid for the first time is dysphoric rather than euphoric, and nausea and vomiting may result.

Course. The factors involved in rapidity of onset and the duration of intoxication are discussed in the text on Intoxication as an Organic Brain Syndrome (p. 121).

A single dose of morphine taken intravenously will reach its peak subjective effect in 5 minutes or less. The effect lasts from 4 to 6 hours and is usually followed by a "down" feeling.

Complications. The most serious complication is opioid poisoning, manifested by coma, shock, pinpoint pupils, and depressed respiration, with the possibility of death from respiratory arrest. This syndrome can be rapidly reversed by intravenous administration of a narcotic antagonist such as naloxone, nalorphine, or levallorphan if this treatment is given before irreversible brain anoxia has occurred.

Other complications are similar to those of Alcohol Intoxication, but are less commonly seen (see p. 130).

Differential diagnosis. Other Substance-induced Intoxications may cause a similar clinical picture. Barbiturates and alcohol are most likely to be confused in this regard. **Barbiturate** and **Alcohol Intoxication** can be distinguished by the absence of pupillary constriction in the latter and by the use of laboratory tests. A mild **Hallucinogen Hallucinosis** may occasionally cause a similar picture. **Cocaine, amphetamines,** and **hallucinogens** cause pupillary dilation; but unless the individual is in a state of severe intoxication, the possibility that this dilation is a sign of Opioid Intoxication is unlikely.

Diagnostic criteria for Opioid Intoxication

A. Recent use of an opioid.

B. Pupillary constriction (or pupillary dilation due to anoxia from severe overdose).

C. At least one of the following psychological signs:

(1) euphoria
(2) dysphoria
(3) apathy
(4) psychomotor retardation

D. At least one of the following neurological signs:

(1) drowsiness
(2) slurred speech
(3) impairment in attention or memory

E. Maladaptive behavioral effects, e.g., impaired judgment, interference with social or occupational functioning.

F. Not due to any other physical or mental disorder.

292.00 Opioid Withdrawal

The essential feature is a characteristic withdrawal syndrome due to recent cessation of or reduction in use of an opioid. The syndrome includes lacrimation, rhinorrhea, pupillary dilation, piloerection, sweating, diarrhea, yawning, mild hypertension, tachycardia, fever, and insomnia.

The symptoms and signs of Opioid Withdrawal may be precipitated by the abrupt cessation of opioid administration after a one- or two-week period of continuous use or by administration of a narcotic antagonist (e.g., naloxone or nalorphine) after therapeutic doses of an opioid given four times a day for as short a period as three or four days.

Associated features. Common associated features include restlessness, irritability, depression, tremor, weakness, nausea, vomiting, and muscle and joint pains. These symptoms together with the symptoms noted above resemble the clinical picture of influenza.

Depending on the observer and the environment, there may be complaints, pleas, demands, and manipulations all directed toward the goal of obtaining more opioids. A need for analgesia may be simulated or the withdrawal symptoms may be exaggerated.

Course. Mild Opioid Withdrawal may occur after abrupt withdrawal of analgesic doses of morphine after 7 to 10 days of administration. However, it is relatively uncommon for opioid craving to occur in the context of analgesic administration for pain from physical disorders or associated with surgery. The withdrawal symptoms with full-blown craving for opioids usually occur secondary to abrupt withdrawal in individuals dependent on opioids. In the case of morphine or heroin, the first withdrawal signs are usually noted within 6 to 8 hours of the previous dose, reach a peak on the second or third day, and disappear in 7 to 10 days.

The withdrawal syndrome from meperidine begins more quickly after the last dose, reaches a peak within 8 to 12 hours, and is over within 4 or 5 days. Methadone withdrawal may not begin for 1 to 3 days after the last dose, and then may be relatively mild. The symptoms are usually over by the 10th to 14th day.

Withdrawal symptoms from semisynthetic and synthetic opioids are qualitatively similar to those from morphine, the general rule being that substances with a short duration of action tend to produce short, intense, withdrawal syndromes whereas substances that are slowly eliminated produce withdrawal syndromes that are prolonged but milder. However, narcotic antagonist-precipitated

withdrawal following administration of long-acting substances can be quite severe.

Complications. Death rarely occurs unless the individual has a severe physical disorder, such as cardiac disease.

Differential diagnosis. Influenza is remarkably similar in its clinical picture to Opioid Withdrawal.

Other substance withdrawals and **mixed withdrawals,** especially **Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal,** can be differentiated from Opioid Withdrawal by testing of blood and urine and by taking a careful history, bearing in mind that individuals giving such a history are often unreliable. Third-party confirmation is extremely valuable.

Diagnostic criteria for Opioid Withdrawal

A. Prolonged, heavy use of an opioid (or administration of a narcotic antagonist following a briefer period of use).

B. At least four of the following symptoms due to the recent cessation of or reduction in opioid use:

(1) lacrimation
(2) rhinorrhea
(3) pupillary dilation
(4) piloerection
(5) sweating
(6) diarrhea
(7) yawning
(8) mild hypertension
(9) tachycardia
(10) fever
(11) insomnia

C. Not due to any other physical or mental disorder.

COCAINE ORGANIC MENTAL DISORDER

Cocaine is usually applied to the mucous membrane of the nose by sniffing the crystalline flakes or powder. Intravenous administration is sometimes preferred, most commonly by opioid users who mix cocaine with heroin, a combination referred to as "speedball." Cocaine "base" is smoked in pipes or cigarettes, and has effects similar to cocaine taken intravenously.

There is apparently no withdrawal syndrome.

305.60 Cocaine Intoxication

The essential features are specific psychological and physical symptoms and maladaptive behavioral effects due to the recent use of cocaine. The psychological

symptoms typically include a sense of well-being and confidence, with heightened awareness of sensory input. There may be psychomotor agitation, elation, grandiosity, loquacity, pacing about, and pressured speech. The physical symptoms include tachycardia, pupillary dilation, elevated blood pressure, perspiration or chills, nausea and vomiting, anorexia, and insomnia. The psychological and physical symptoms begin no longer than one hour after administration, and may occur within a few minutes.

The maladaptive behavioral effects may include fighting, impaired judgment, and interference with social or occupational functioning.

Associated features. If taken intravenously or smoked, cocaine produces a characteristic "rush" of well-being and confidence. If the intoxication is severe, there is likely to be confusion, rambling or even incoherent speech, anxiety, and apprehension. There may be headache and palpitations. Intoxication with intravenous administration of high doses of cocaine may be associated with transient ideas of reference, paranoid ideation, a subjective sense of "profound thoughts," increased sexual interest, ringing in the ears, hearing one's name called, and a sensation of insects crawling up the skin (formication) or seeing insects. There sometimes are increased curiosity and bizarre behavior, such as sorting objects into various piles. Stereotyped movements of mouth and tongue are sometimes noted.

One hour or longer after the characteristic behavioral and physical effects have subsided, anxiety, tremulousness, irritability, and feelings of fatigue and depression often ensue. During this period, referred to as "crashing," there often is a craving for more cocaine.

Course. The course of Cocaine Intoxication is usually self-limited, with full recovery within 24 hours.

Complications. Syncope or chest pain may occur. There may be seizures following large doses. Death may result from cardiac arrhythmias or respiratory paralysis.

Differential diagnosis. Manic episode may present with symptoms similar to those seen in Cocaine Intoxication. **Amphetamine Intoxication** and **Phencyclidine (PCP) Intoxication** may cause a similar clinical picture, and can be distinguished from Cocaine Intoxication only by the presence of cocaine metabolites in a urine specimen or cocaine in plasma.

Diagnostic criteria for Cocaine Intoxication

A. Recent use of cocaine.

B. At least two of the following psychological symptoms within one hour of using cocaine:

(1) psychomotor agitation
(2) elation
(3) grandiosity
(4) loquacity
(5) hypervigilance

C. At least two of the following symptoms within one hour of using cocaine:

(1) tachycardia
(2) pupillary dilation
(3) elevated blood pressure
(4) perspiration or chills
(5) nausea and vomiting

D. Maladaptive behavioral effects, e.g., fighting, impaired judgment, interference with social or occupational functioning.

E. Not due to any other physical or mental disorder.

AMPHETAMINE OR SIMILARLY ACTING SYMPATHOMIMETIC ORGANIC MENTAL DISORDERS

This group includes all of the substances of the substituted phenylethylamine structure, such as amphetamine, dextroamphetamine, and methamphetamine ("speed"), and those with structures differing from the substituted phenylethylamine that have amphetamine-like action, such as methylphenidate or some substances used as appetite suppressants ("diet pills"). These substances are taken orally or intravenously.

305.70 Amphetamine or Similarly Acting Sympathomimetic Intoxication

The essential features are specific psychological and physical symptoms and maladaptive behavioral effects due to the recent use of amphetamine or similarly acting sympathomimetic substances.

All of the features (essential, associated, course, complications, and differential diagnosis) are virtually identical with those of Cocaine Intoxication. One exception is that delusions or hallucinations are always transient in Cocaine Intoxication, whereas in the intoxication due to amphetamine or similarly acting sympathomimetic substances, they may persist beyond the time of direct substance effect. When this occurs, the syndrome is then referred to as an Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder (p. 149). The other exception is that on occasion an intoxication from this class of substances may develop into a Delirium.

Diagnostic criteria for Amphetamine or Similarly Acting Sympathomimetic Intoxication

A. Recent use of amphetamine or similarly acting sympathomimetic.

B. Within one hour of use, at least two of the following psychological symptoms:

(1) psychomotor agitation
(2) elation
(3) grandiosity
(4) loquacity
(5) hypervigilance

C. Within one hour of use, at least two of the following physical symptoms:

(1) tachycardia
(2) pupillary dilation
(3) elevated blood pressure
(4) perspiration or chills
(5) nausea or vomiting

D. Maladaptive behavioral effects, e.g., fighting, impaired judgment, interference with social or occupational functioning.

E. Not due to any other physical or mental disorder.

292.81 Amphetamine or Similarly Acting Sympathomimetic Delirium
The essential feature is a Delirium (p. 104) within 24 hours of intake of an amphetamine or similarly acting sympathomimetic.

Associated features. Tactile and olfactory hallucinations may be present. Affect is often labile. Violent or aggressive behavior is common, and restraint may be required.

Course. Delirium usually occurs within one hour of substance use and is over in about six hours. When the substance is taken intravenously, the onset is almost immediate. More rarely the Delirium follows a period of intoxication. When the other pharmacological effects of the substance have worn off, the Delirium disappears completely.

Complications. See Cocaine Intoxication, p. 146.

Prevalence. This disorder is not as common as Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder.

Differential diagnosis. See differential diagnosis of Delirium, p. 106.

Diagnostic criteria for Amphetamine or Similiarly Acting Sympathomimetic Delirium

A. Delirium (p. 107) within 24 hours of use of amphetamine or similarly acting sympathomimetic.

B. Not due to any other physical or mental disorder.

292.11 Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder

The essential feature is an Organic Delusional Syndrome (p. 114) following recent use of an amphetamine or similarly acting sympathomimetic during a period of long-term use of moderate or high doses of the substance. (The syndrome apparently does not develop following a single large dose unless preceded by chronic use.) The syndrome develops rapidly. Persecutory delusions are the predominant clinical feature; in addition, there are ideas of reference, aggressiveness and hostility, anxiety, or psychomotor agitation.

Associated features. Distortion of body image and misperception of people's faces may occur. Initially, suspiciousness and curiosity may be experienced with pleasure. However, suspiciousness and paranoid delusions may later induce aggressive or violent action against "enemies." The hallucination of bugs or vermin crawling in or under the skin (formication) can lead to scratching and extensive skin excoriations.

Course. Delusions can linger for a week or more, but occasionally last for over a year.

Impairment, complications, and differential diagnosis. See Organic Delusional Syndrome, p. 114.

Diagnostic criteria for Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder

A. Recent use of amphetamine or similarly acting sympathomimetic during a period of long-term use of moderate or high doses.

B. A rapidly developing syndrome consisting of persecutory delusions as the predominant clinical feature and at least three of the following:

(1) ideas of reference
(2) aggressiveness and hostility

(3) anxiety
(4) psychomotor agitation

C. Not due to any other physical or mental disorder.

292.00 Amphetamine or Similarly Acting Sympathomimetic Withdrawal
The essential feature is a characteristic withdrawal syndrome due to recent cessation of or reduction in use of amphetamine or a similarly acting sympathomimetic. The syndrome always involves depressed mood, plus fatigue, disturbed sleep, or increased dreaming.

Associated features. If the depressed mood is severe, other symptoms of the depressive syndrome, such as agitation or suicidal ideation, may be present. The disturbed sleep is usually related to increased REM sleep activity, and may last for weeks.

Course. The syndrome develops within three days of cessation of or reduction in substance use. The symptoms reach a peak at two to four days, although depression and irritability may persist for months.

Complications. A Depressive Disorder and suicide are the major complications.

Differential diagnosis. A coexisting **Depressive Disorder** should be considered if a depressive syndrome persists for several weeks.

Diagnostic criteria for Amphetamine or Similarly Acting Sympathomimetic Withdrawal
A. Prolonged heavy use of amphetamine or a similarly acting sympathomimetic.

B. After cessation of or reduction in substance use, depressed mood and at least two of the following:

(1) fatigue
(2) disturbed sleep
(3) increased dreaming

C. Not due to any other physical or mental disorder, such as Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder.

PHENCYCLIDINE (PCP) OR SIMILARLY ACTING ARYLCYCLOHEXYLAMINE ORGANIC MENTAL DISORDERS

This group of substances includes phencyclidine and similarly acting compounds such as ketamine (Ketalar) and the thiophene analogue of phencyclidine (TCP).

These substances can be taken orally or parenterally or can be smoked or inhaled. Within this class of substances, phencyclidine is the most commonly used. It is sold on the street under a variety of names, the most common of which are PCP, PeaCe Pill, angel dust, THC, and crystal.

305.90 Phencyclidine or Similarly Acting Arylcylohexylamine Intoxication
The essential features are specific physical and psychological symptoms associated with maladaptive behavioral effects due to the recent use of phencyclidine or a similarly acting arylcyclohexylamine. The symptoms begin within one hour of oral ingestion of the substance; if smoked, insufflated, or taken intravenously, onset may be within 5 minutes. The physical symptoms include vertical and horizontal nystagmus, elevated blood pressure, numbness or diminished responsiveness to pain, ataxia, dysarthria, and diaphoresis or increased salivation. Psychological symptoms include euphoria, psychomotor agitation, anxiety, emotional lability, grandiosity, a sensation of slowed time, and synesthesias (e.g., seeing colors when a loud sound occurs).

The effects of this class of substance are generally dose related, although there is great variability among individuals. The effects usually range from a mild, "floaty" euphoria and numbness after ingesting less than 5 mg of phencyclidine, to muscle rigidity, hypertension, and a noncommunicative state following a dose of 5-10 mg, and coma, convulsions, and possible death after a dose of 20 mg or more of phencyclidine.

Associated features. Intoxication may be accompanied by repetitive motor movements, including facial grimacing, muscle rigidity on stimulation, and repeated episodes of vomiting. There may also be hallucinations, paranoid ideation, and bizarre or violent behavior.

Course. In most cases, individuals who are acutely confused following ingestion of phencyclidine or a similarly acting arylcyclohexylamine are alert and oriented within 3-4 hours of admission to an emergency room. Chronic users of phencyclidine report feeling intoxicated for 4-6 hours after ingesting the usual "street" dose.

Complications. Death from respiratory depression can occur following a high dose. Suicide is not uncommon during acute intoxication. While an individual is recovering from an intoxicated state, depression, irritability, and nervousness often occur.

Differential diagnosis. Other Substance-induced Intoxications that cause a similar clinical picture, such as those due to amphetamines and hallucinogens, may be ruled out by the presence of phencyclidine in the urine or plasma.

Diagnostic criteria for Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Intoxication
A. Recent use of phencyclidine or a similarly acting arylcyclohexylamine.

B. Within an hour (less when smoked, insufflated, or used intravenously), at least two of the following physical symptoms:

(1) vertical or horizontal nystagmus
(2) increased blood pressure and heart rate
(3) numbness or diminished responsiveness to pain
(4) ataxia
(5) dysarthria

C. Within one hour, at least two of the following psychological symptoms:

(1) euphoria
(2) psychomotor agitation
(3) marked anxiety
(4) emotional lability
(5) grandiosity
(6) sensation of slowed time
(7) synesthesias

D. Maladaptive behavioral effects, e.g., belligerence, impulsivity, unpredictability, impaired judgment, assaultiveness.

E. Not due to any other physical or mental disorder, e.g., Delirium.

292.81 Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Delirium

The essential feature is a Delirium (p. 104) due to phencyclidine (PCP) or a similarly acting arylcyclohexylamine. The Delirium may occur within 24 hours after use or may emerge following recovery from an overdose days after the substance has been taken.

Associated features. See Phencyclidine Intoxication, p. 151.

Course. The Delirium may last up to a week, with waxing and waning that is probably a reflection of excretion into and reabsorption from the stomach.

Complications. See Phencyclidine Intoxication, p. 151.

Prevalence. This disorder is not as common as Intoxication from this class of substances.

Differential diagnosis. See differential diagnosis of Delirium, p. 106.

Diagnostic criteria for Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Delirium

A. Delirium (p. 107) due to phencyclidine (PCP) or similarly acting arylcyclohexylamine.

B. Not due to any other physical or mental disorder.

292.90 Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Mixed Organic Mental Disorder

The essential feature is recent use of phencyclidine or a similarly acting arylcyclohexylamine that has resulted in an illness that involves features of several Organic Brain Syndromes or a progression from one Organic Brain Syndrome to another. For example, an individual may simultaneously have prominent delusions, hallucinations, and signs of disorientation, or may initially have a Delirium, followed by an Organic Delusional Syndrome.

Diagnostic criteria for Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Mixed Organic Mental Disorder

A. There is evidence of recent use of phencyclidine or a similarly acting arylcyclohexylamine.

B. The resulting illness involves features of several Organic Brain Syndromes or a progression from one Organic Brain Syndrome to another, e.g., initially there is Delirium, followed by an Organic Delusional Syndrome.

HALLUCINOGEN ORGANIC MENTAL DISORDERS

This group includes two types of substances, both of which have hallucinogenic properties: substances structurally related to 5-hydroxytryptamine (e.g., lysergic acid diethylamine [LSD] and dimethyltryptamine [DMT]), and substances related to catecholamine (e.g., mescaline).* These substances are taken orally.

305.30 Hallucinogen Hallucinosis

The essential features are characteristic perceptual changes, physical symptoms, and maladaptive behavioral effects due to recent hallucinogen ingestion. The perceptual changes include subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, or synesthesias (e.g., seeing colors when a loud sound occurs). These occur in a state of full wakefulness and alertness. There may be hyperacusis and overattention to detail. The illusions may

* Phencyclidine (PCP), although it has been referred to as an hallucinogen, is classified separately (p. 150) since it rarely causes a pure hallucinosis.

involve distortions of the individual's body image. The hallucinations are usually visual, often of geometric forms and figures, sometimes of persons and objects. More rarely, auditory and tactile hallucinations are experienced.

Physical symptoms include pupillary dilation, tachycardia, sweating, palpitations, blurring of vision, tremors, and incoordination.

The maladaptive behavioral effects may take the form of marked anxiety or depression, fear of losing one's mind, ideas of reference, paranoid ideation, impaired judgment, interference with social or occupational functioning, or failure to meet responsibilities.

This category is called an Hallucinosis even though it is recognized that frequently, with low doses, the perceptual changes do not include hallucinations.

Associated features. The associated features are heavily influenced by the setting in which the syndrome occurs, the dose, and the expectations and personality of the individual. Euphoria is common. Usually the individual realizes that the perceptual changes are due to the effect of the hallucinogen. More rarely, the individual is convinced that he or she has lost his or her sanity and will not regain it.

Imagery and thoughts are often dominated by mystical or religious experiences. For example, the individual may believe that he or she has achieved certain insights not possible otherwise.

Course. The onset is usually within an hour of ingestion. In the case of LSD, the most commonly used hallucinogen, the disorder lasts about 6 hours. For other hallucinogens the duration may range from under an hour to a day or two, at most, three days.

Complications. In rare cases the individual will act irrationally and may harm himself or herself or others. "Flashback" hallucinations (recurrent hallucinations after the hallucinogen is no longer present in the body) can occur. Hallucinogen Delusional Disorder and Hallucinogen Affective Disorder are possible complications.

Differential diagnosis. See Organic Hallucinosis, p. 116. Various **Substance-induced Intoxications,** such as that due to **cannabis,** cause clinical pictures similar to the Hallucinogen Hallucinosis that results from low doses. In such cases, if an adequate history is not available, laboratory tests should be used to make the diagnosis.

Diagnostic criteria for Hallucinogen Hallucinosis

A. Recent ingestion of a hallucinogen.

B. Perceptual changes occurring in a state of full wakefulness and alertness, e.g., subjective intensification of perceptions, depersonalization, derealization, illusions, hallucinations, synesthesias.

C. At least two of the following physical symptoms:

(1) pupillary dilation
(2) tachycardia
(3) sweating
(4) palpitations
(5) blurring of vision
(6) tremors
(7) incoordination

D. Maladaptive behavioral effects, e.g., marked anxiety or depression, ideas of reference, fear of losing one's mind, paranoid ideation, impaired judgment, interference with social or occupational functioning.

E. Not due to any other physical or mental disorder.

292.11 Hallucinogen Delusional Disorder

The essential feature is an Organic Delusional Syndrome (p. 114) that persists beyond the period of direct effect of the hallucinogen, i.e., 24 hours after cessation of hallucinogen use.

The Organic Delusional Syndrome emerges during or following a Hallucinogen Hallucinosis (p. 153). All of the perceptual changes described in Hallucinogen Hallucinosis may occur; but, in addition, the individual has a delusional conviction that the disturbed perceptions and thoughts correspond to reality.

Course. The course is variable, and may range from a brief, transitory experience to a long-lasting, psychotic episode that is difficult to distinguish from a nonorganic psychotic disorder, such as Schizophreniform Disorder or Acute Paranoid Disorder.

Complications. See Hallucinogen Hallucinosis, p. 154.

Differential diagnosis. See Organic Delusional Syndrome, p. 114. A pre-existing **nonorganic psychotic disorder** should be considered if a Hallucinogen Delusional Disorder persists.

Diagnostic criteria for Hallucinogen Delusional Disorder

A. Recent hallucinogen use.

B. Development of an Organic Delusional Syndrome (p. 115) that persists beyond 24 hours after cessation of hallucinogen use.

C. Not due to any other physical or mental disorder, such as Schizophrenia.

292.84 Hallucinogen Affective Disorder

The essential feature is an Organic Affective Syndrome (p. 117) that persists beyond the period of direct effect of the hallucinogen, i.e., 24 hours after cessation of hallucinogen use.

Typically, the mood emerges shortly after hallucinogen use. Most common is the appearance of depression or anxiety; elation is rare. The depressive features often include feelings of self-reproach or excessive or inappropriate guilt, accompanied by fearfulness, tension, and physical restlessness. The individual may be unable to stop talking and have difficulty sleeping. Such individuals are frequently preoccupied with thoughts that they have destroyed their brains, that they have driven themselves crazy and will be unable to return to their normal state. These thoughts are without delusional conviction. When there is elation, grandiosity, decreased need for sleep, distractibility, increased activity, and loquacity are also present.

Course. The course is variable, and may range from a brief, transitory experience to a long-lasting episode that is difficult to distinguish from an Affective Disorder.

Complications. Manic and major depressive episodes.

Differential diagnosis. An individual with a preexisting **Affective Disorder** may take an hallucinogen to elevate his or her mood and then become more depressed. In such cases it may be difficult or impossible to determine if the increased disturbance in mood is due to Hallucinogen Affective Disorder or is merely an exacerbation of the Affective Disorder. See Organic Affective Syndrome, p. 117.

Hallucinogen Delusional Disorder may also be accompanied by marked affective changes. This diagnosis preempts a diagnosis of Hallucinogen Affective Disorder.

Diagnostic criteria for Hallucinogen Affective Disorder

A. Recent use of a hallucinogen.

B. Development of an Organic Affective Syndrome (p. 118) that persists beyond 24 hours after cessation of hallucinogen use.

C. Absence of delusions.

D. Not due to any other physical or mental disorder, such as pre-existing Affective Disorder.

CANNABIS ORGANIC MENTAL DISORDERS

This group includes all substances with psychoactive properties from the cannabis plant as well as chemically similar synthetic substances. In the United States

the most commonly used substances are marijuana, hashish, and, occasionally, purified delta-9-tetrahydrocannabinol (THC). These substances are smoked or taken orally in a number of forms, including mixed with food.

305.20 Cannabis Intoxication

The essential features are specific psychological and physical symptoms and maladaptive behavioral effects due to the recent use of cannabis.

The psychological symptoms include euphoria, subjective intensification of perceptions, the sensation of slowed time (5 minutes may seem like an hour), preoccupation with auditory or visual stimuli, and apathy. The euphoria may be expressed as a marked sense of well-being and relaxation. The individual may be indifferent to his or her surroundings.

Tachycardia is invariably present, although it is not as prominent when the individual is a chronic user of cannabis. Conjunctival injection is almost always present. Other physical symptoms include increased appetite, often for "junk food," and a dry mouth.

Maladaptive behavioral effects include paranoid ideation, panic attacks, and dysphoric affects. The individual may believe that he or she is dying or going crazy. (Some believe that adverse reactions are more likely to occur in individuals with rigid personalities, in individuals with a history of having had a psychotic disorder, or in circumstances considered to be threatening, such as the possibility of a police raid.) Other maladaptive behavioral effects include impaired judgment and interference with social or occupational functioning.

Associated features. Depersonalization or derealization may occur. Hallucinations are rare except when very high blood levels are reached. (In such circumstances, the substance acts as an hallucinogen. Because this rarely occurs, a separate diagnosis of Cannabis Hallucinosis is not included in this classification.)

Course. Intoxication occurs almost immediately after smoking marijuana, peaks within a half hour, and usually lasts about 3 hours. Orally ingested cannabis is more slowly absorbed and reaches a lower peak blood level, and the effects last longer.

Complications. Automobile accidents may occur because of impaired motor coordination.

Differential diagnosis. Other Substance-induced Intoxications should be considered. The individual with Cannabis Intoxication will sometimes have the characteristic sweet smell of burned cannabis on his or her clothing. **Alcohol Intoxication** frequently decreases appetite, increases aggressive behavior, produces nystagmus or ataxia, and is associated with the smell of alcohol, whereas these symptoms are rare in Cannabis Intoxication. **Hallucinogens** in low doses cause a clinical picture that resembles Cannabis Intoxication. If the administration was by smoking, this would indicate Cannabis Intoxication, since hallucinogens are not smoked. If administration was by ingestion, Cannabis Intoxication still must be considered.

Diagnostic criteria for Cannabis Intoxication
A. Recent use of cannabis.

B. Tachycardia.

C. At least one of the following psychological symptoms within 2 hours of use:

(1) euphoria
(2) subjective intensification of perceptions
(3) sensation of slowed time
(4) apathy

D. At least one of the following physical symptoms within 2 hours of substance use:

(1) conjunctival injection
(2) increased appetite
(3) dry mouth

E. Maladaptive behavioral effects, e.g., excessive anxiety, suspiciousness or paranoid ideation, impaired judgment, interference with social or occupational functioning.

F. Not due to any other physical or mental disorder.

292.11 Cannabis Delusional Disorder
The essential feature is an Organic Delusional Syndrome (p. 114), usually with persecutory delusions, immediately following cannabis use or during the course of Cannabis Intoxication.

The existence of this category is controversial since the disturbance does not persist beyond a few hours, the usual duration of Cannabis Intoxication.

Associated features. Marked anxiety, emotional lability, depersonalization, and subsequent amnesia for the episode can occur. Associated physical symptoms are the same as those seen in Cannabis Intoxication.

Differential diagnosis. See Organic Delusional Syndrome, p. 114.

Diagnostic criteria for Cannabis Delusional Disorder
A. Recent use of cannabis.

B. An Organic Delusional Syndrome (p. 115) within 2 hours of substance use.

C. The disturbance does not persist beyond 6 hours following cessation of substance use.

D. Not due to any other physical or mental disorder.

TOBACCO ORGANIC MENTAL DISORDER

292.00 Tobacco Withdrawal

The essential feature is a characteristic withdrawal syndrome due to recent cessation of or reduction in tobacco use that has been at least moderate in duration and amount. The syndrome includes craving for tobacco, irritability, anxiety, difficulty concentrating, restlessness, headache, drowsiness, and gastrointestinal disturbances. It is assumed that this syndrome is caused by nicotine withdrawal, since nicotine is the major pharmacologically active ingredient in tobacco.

Withdrawal does not occur with all smokers; but in many heavy cigarette smokers, changes in mood and performance that are probably related to withdrawal can be detected within 2 hours after the last cigarette. The sense of craving appears to reach a peak within the first 24 hours after the last cigarette, thereafter gradually declining over a few days to several weeks. In any given case it is difficult to distinguish between a withdrawal effect and the emergence of psychological traits that were suppressed, controlled, or altered by the effects of nicotine.

Associated features. Increased slow rhythms on the EEG, increased frequency of masseter muscle contractions, decreased heart rate and blood pressure, weight gain, and impairment in performance of tasks requiring vigilance are common associated features of Tobacco Withdrawal.

Course. The symptoms begin within 24 hours of cessation of or reduction in tobacco use and decrease in intensity over a period of a few days to several weeks.

Differential diagnosis. The diagnosis of Tobacco Withdrawal is usually self-evident from the individual's history, and the disappearance of symptoms if smoking is resumed is confirmatory.

Diagnostic criteria for Tobacco Withdrawal

A. Use of tobacco for at least several weeks at a level equivalent to more than ten cigarettes per day, with each cigarette containing at least 0.5 mg of nicotine.

B. Abrupt cessation of or reduction in tobacco use, followed within 24 hours by at least four of the following:

(1) craving for tobacco
(2) irritability
(3) anxiety
(4) difficulty concentrating
(5) restlessness
(6) headache
(7) drowsiness
(8) gastrointestinal disturbances

CAFFEINE ORGANIC MENTAL DISORDER

The consumption of caffeine, especially in the form of coffee, tea, cola, chocolate, and cocoa, is ubiquitous in the United States. Other common sources of caffeine are over-the-counter analgesics, "cold" preparations, and stimulants.

305.90 Caffeine Intoxication

The essential features are such characteristic effects of the recent use of caffeine-containing substances as restlessness, nervousness, excitement, insomnia, flushed face, diuresis, and gastrointestinal complaints. These symptoms appear in some individuals following ingestion of as little as 250 mg of caffeine per day, whereas others require much larger doses. At levels of more than 1 g/day there may be muscle twitchings, periods of inexhaustibility, psychomotor agitation, rambling flow of thought and speech, and cardiac arrhythmia. Mild sensory disturbances such as ringing in the ears and flashes of light have been reported at higher doses. With doses exceeding 10 g of caffeine, grand mal seizures and respiratory failure may result in death.

This disorder has been called Caffeinism.

A rough guide to calculating caffeine intake follows: coffee contains 100-150 mg of caffeine per cup; tea is about half as strong; a glass of cola is about a third as strong. Most caffeine-containing prescriptions and over-the-counter medications are one-third to one-half the strength of a cup of coffee. Two notable exceptions are migraine medications and over-the-counter stimulants that contain 100 mg per tablet.

Complications. Complications include developing or aggravating gastrointestinal and heart disease. Caffeine can produce epigastric distress and, occasionally, peptic ulcer and hematemesis. In addition to arrhythmia with extremely high dosages, the substance can cause marked hypotension and circulatory failure.

Differential diagnosis. Manic episodes, Panic Disorder or **Generalized Anxiety Disorder** can cause a clinical picture similar to that of Caffeine Intoxication. The temporal relationship of the symptoms to caffeine use establishes the diagnosis.

Diagnostic criteria for Caffeine Intoxication

A. Recent consumption of caffeine, usually in excess of 250 mg.

B. At least five of the following:

(1) restlessness
(2) nervousness
(3) excitement
(4) insomnia
(5) flushed face
(6) diuresis
(7) gastrointestinal complaints
(8) muscle twitching
(9) rambling flow of thought and speech
(10) cardiac arrhythmia
(11) periods of inexhaustibility
(12) psychomotor agitation

C. Not due to any other mental disorder, such as an Anxiety Disorder.

OTHER OR UNSPECIFIED SUBSTANCE-INDUCED ORGANIC MENTAL DISORDERS

This section is to be used when an individual develops an Organic Brain Syndrome apparently due to use of a substance if:

(1) the substance cannot be classified in any of the ten previously listed categories (examples: Levo-dopa Delusional Disorder, Anticholinergic Delirium); or

(2) the syndrome is caused by an unknown substance (example: an Intoxication after taking a bottle of unlabeled pills).

Following the listing of each of the diagnoses in this section, the reader is directed to the page listing the diagnostic criteria for the various Organic Brain Syndromes.

305.90 Other or Unspecified Substance Intoxication (p. 120)

292.00 Other or Unspecified Substance Withdrawal (p. 122)

292.81 Other or Unspecified Substance Delirium (p. 104)

292.82 Other or Unspecified Substance Dementia (p. 107)

292.83 Other or Unspecified Substance Amnestic Disorder (p. 112)

292.11 Other or Unspecified Substance Delusional Disorder (p. 114)

292.12 Other or Unspecified Substance Hallucinosis (p. 115)

292.84 Other or Unspecified Substance Affective Disorder (p. 117)

292.89 Other or Unspecified Substance Personality Disorder (p. 118)

292.90 Other or Unspecified Substance Atypical or Mixed Organic Mental Disorder (p. 123)

ORGANIC MENTAL DISORDERS—SECTION 2

Organic Mental Disorders in which the etiology or pathophysiological process is either noted on Axis III as an additional diagnosis from outside of the mental disorders section of ICD-9-CM or is unknown.

This section permits the identification of specific Organic Brain Syndromes on Axis I, associated with physical disorders noted on Axis III. Examples would include Delirium (Axis I) associated with pneumonia (Axis III) and Dementia (Axis I) associated with brain tumor (Axis III). Following the name of each of the Organic Brain Syndromes is the page listing the diagnostic criteria for the syndrome.

293.00 Delirium (p. 107)

294.10 Dementia (p. 111)

294.00 Amnestic Syndrome (p. 113)

293.81 Organic Delusional Syndrome (p. 115)

293.82 Organic Hallucinosis (p. 116)

293.83 Organic Affective Syndrome (p. 118)

310.10 Organic Personality Syndrome (p. 119)

294.80 Atypical or Mixed Organic Brain Syndrome (p. 123)

Substance Use Disorders

In our society, use of certain substances to modify mood or behavior under certain circumstances is generally regarded as normal and appropriate. Such use includes recreational drinking of alcohol, in which a majority of adult Americans participate, and the use of caffeine as a stimulant in the form of coffee. On the other hand, there are wide subcultural variations. In some groups even the recreational use of alcohol is frowned upon, while in other groups the use of various illegal substances for recreational purposes is widely accepted. In addition, certain substances are used medically for the alleviation of pain, relief of tension, or to suppress appetite.

This diagnostic class deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system. These behavioral changes in almost all subcultures would be viewed as extremely undesirable. Examples of such behavioral changes include impairment in social or occupational functioning as a consequence of substance use, inability to control use of or to stop taking the substance, and the development of serious withdrawal symptoms after cessation of or reduction in substance use. These conditions are here conceptualized as mental disorders and are therefore to be distinguished from nonpathological substance use for recreational or medical purposes.

The disorders classified in this section are to be distinguished from the corresponding portions of the Organic Mental Disorders section. Whereas the Substance Use Disorders refer to the maladaptive behavior associated with more or less regular use of the substances, the Substance-induced Organic Mental Disorders describe the direct acute or chronic effects of these substances on the central nervous system. Almost invariably, individuals who have a Substance Use Disorder will also at various times have a Substance-induced Organic Mental Disorder, such as an Intoxication or Withdrawal.

For most classes of substances, pathological use is divided into Substance Abuse and Substance Dependence, defined below:

SUBSTANCE ABUSE

Pattern of pathological use

Impairment in social or occupational functioning due to substance use

Minimal duration of disturbance of at least one month

SUBSTANCE DEPENDENCE

Tolerance or withdrawal

(For Alcohol Dependence and Cannabis Dependence a pattern of pathological use or impairment in social or occupational functioning is also required. For the exception of Tobacco Dependence, see p. 176.)

SUBSTANCE ABUSE

Three criteria distinguish nonpathological substance use from Substance Abuse.

A pattern of pathological use. Depending upon the substance, this may be manifested by: intoxication throughout the day, inability to cut down or stop use, repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day, continuation of substance use despite a serious physical disorder that the individual knows is exacerbated by use of the substance, need for daily use of the substance for adequate functioning, and episodes of a complication of the substance intoxication (e.g., alcoholic blackouts, opioid overdose).

Impairment in social or occupational functioning caused by the pattern of pathological use. Social relations can be disturbed by the individual's failure to meet important obligations to friends and family, by display of erratic and impulsive behavior, and by inappropriate expression of aggressive feelings. The individual may have legal difficulties because of complications of the intoxicated state (e.g., car accidents) or because of criminal behavior to obtain money to purchase the substance. (However, legal difficulties due to possession, purchase, or sale of illegal substances are highly dependent on local customs and laws, and change over time. For this reason, such legal difficulty on a single occasion should not be considered in the evaluation of impairment in social functioning for diagnostic purposes.)

Occupational functioning can deteriorate if the individual misses work or school, or is unable to function effectively because of being intoxicated. When impairment is severe, the individual's life can become totally dominated by use of the substance, with marked deterioration in physical and psychological functioning. Incapacitation is more frequently associated with chronic Opioid and Alcohol Dependence than with dependence on other substances.

Frequently individuals who develop Substance Use Disorders also have preexisting Personality Disorders and Affective Disorders with concomitant impairment in social and occupational functioning. It is therefore necessary to determine that the social or occupational impairment associated with the diagnosis of Substance Abuse or Dependence is actually due to the use of the substance. The best clue is a change in functioning that accompanies the onset of a pathological pattern of substance use, or the development of physiological dependence.

Duration. Abuse as used in this manual requires that the disturbance last at least *one month.* Signs of the disturbance need not be present continuously throughout the month, but should be sufficiently frequent for a *pattern* of pathological use causing interference with social or occupational functioning to be apparent. For example, several episodes of binge drinking causing family arguments during a one-month period would be sufficient even though between binges the individual's functioning was apparently not impaired.

Isolated instances of pathological use of a substance can be adequately diagnosed by noting the specific Organic Brain Syndromes that were associated with this use. For example, a history of one or more instances of maladaptive use of alcohol over a three-week period may be noted as prior episodes of Alcohol Intoxication.

SUBSTANCE DEPENDENCE

Substance Dependence generally is a more severe form of Substance Use Disorder than Substance Abuse and requires physiological dependence, evidenced by either tolerance or withdrawal. Almost invariably there is also a pattern of pathological use that causes impairment in social or occupational functioning, although in rare cases the manifestations of the disorder are limited to physiological dependence. An example would be an individual's inadvertently becoming physiologically dependent on an analgesic opioid given to him by a physician for the relief of physical pain.

The diagnosis of all of the Substance Dependence categories requires only evidence of tolerance or withdrawal, except for Alcohol and Cannabis Dependence, which in addition require evidence of social or occupational impairment from use of the substance or a pattern of pathological substance use.

Tolerance. Tolerance means that markedly increased amounts of the substance are required to achieve the desired effect or there is a markedly diminished effect with regular use of the same dose. When the substance used is illegal and mixed with various diluents or with other substances, tolerance may be difficult to determine. In the case of alcohol, it should be noted that there are wide individual variations in the capacity to drink large quantities of alcohol without intoxication. Since some persons have the capacity to drink large amounts despite limited drinking experience, the distinguished feature of tolerance is that the individual reports that the amount of alcohol he or she can drink before showing signs of intoxication has increased markedly over time.

Withdrawal. In withdrawal, a substance-specific syndrome follows cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiological state of intoxication. See Withdrawal as an Organic Brain Syndrome, p. 122.

Many heavy coffee drinkers are physiologically dependent on caffeine and exhibit both tolerance and withdrawal. However, since such use generally does not cause distress or social or occupational impairment, and since few if any of these individuals have difficulty switching to decaffeinated coffee or coffee substitutes, the condition does not appear to be of clinical significance. Therefore, caffeine dependence is not included in this classification of mental disorders. In contrast, Caffeine Intoxication is often clinically significant, and therefore is included (p. 160).

CLASSES OF SUBSTANCES

Five classes of substances are associated with both abuse and dependence: alcohol, barbiturates or similarly acting sedatives or hypnotics, opioids, ampheta-

mines or similarly acting sympathomimetics, and cannabis. Some of these substances are used medically, such as the amphetamines, barbiturates, and opioids. Three classes of substances are associated only with abuse because physiological dependence has not been demonstrated: cocaine, phencyclidine (PCP) or similarly acting arylcyclohexylamines, and hallucinogens. Finally, one substance, tobacco, is associated only with dependence, since heavy use of tobacco itself is not associated with impairment in social or occupational functioning (though the reaction of others to the tobacco use may cause difficulties).

USE OF MULTIPLE SUBSTANCES

Substance Abuse and Dependence frequently involve several substances. Individuals with Barbiturate or Similarly Acting Sedative or Hypnotic Abuse or Dependence often may also have problems with alcohol or, more rarely, use amphetamine to counter sedative effects. Individuals with Opioid or Cannabis Abuse or Dependence usually have several other Substance Use Disorders, particularly of barbiturates or similarly acting sedatives and hypnotics, amphetamines or similarly acting sympathomimetics, and cocaine.

When an individual's condition meets the criteria for more than one Substance Use Disorder, multiple diagnoses should generally be made. (The exception to this is when the abuse or dependence involves so many substances that the clinician prefers to indicate a combination of substances rather than list each specific substance. See p. 179.)

RECORDING SPECIFIC DIAGNOSES

The clinician should record the name of the specific substance rather than of the entire class of substances, using the code number for the appropriate class. Examples: The clinician should write 305.73 Amphetamine Abuse, In Remission (rather than Amphetamine or Similarly Acting Sympathomimetic Abuse); 304.11 Valium Dependence, Continuous (rather than Barbiturate or Similarly Acting Sedative or Hypnotic Dependence); 305.91 Compazine Abuse, Continuous (rather than Other, Mixed, or Unspecified Substance Abuse).

SUBCLASSIFICATION OF COURSE

No entirely adequate method for subtyping the course of these disorders is available. However, the following guidelines should be used to indicate the course of the illness in the fifth digit:

Code	Course	Definition
1	Continuous	More or less regular maladaptive use for over six months.
2	Episodic	A fairly circumscribed period of maladaptive use, with one or more similar periods in the past.
3	In remission	Previous maladaptive use, but not using substance at present. The differentiation of this from no longer ill and from the other course categories requires consideration of the period of time since the last period of disturbance, the total duration of the

Code	Course	Definition
		disturbance, and the need for continued evaluation or prophylactic treatment.
0	Unspecified	Course unknown or first signs of illness with course uncertain.

OTHER FEATURES OF SUBSTANCE USE DISORDERS

Associated features. Personality disturbance and disturbance of mood are often present, and may be intensified by the Substance Use Disorder. For example, antisocial personality traits may be accentuated by the need to obtain money to purchase illegal substances. Anxiety or depression associated with Borderline Personality Disorder may be intensified as the individual uses a substance in an unsuccessful attempt to treat his or her mood disturbance.

Abuse of certain substances, particularly cocaine, hallucinogens, or cannabis, may be associated with identification with countercultural life-styles or, more rarely, identification with non-traditional religious or mystical ideas.

In chronic Abuse and Dependence, mood lability and suspiciousness, both of which can contribute to violent behavior, are common.

Age at onset. Alcohol Abuse and Dependence usually appear in the 20s, 30s, and 40s. Opioid, Cocaine, Amphetamine or Similarly Acting Sympathomimetic, Hallucinogen, Cannabis, Cocaine, Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine, and Tobacco Use Disorders more commonly begin in the late teens and 20s. Two patterns of onset for Barbiturate or Similarly Acting Sedative or Hypnotic Abuse and Dependence have been identified (p. 171). When a Substance Use Disorder begins early in life, it is often associated with failure to complete school and a lifelong pattern of low occupational achievement.

Complications. The abuse or dependence associated with each class of substance may cause an Organic Brain Syndrome. For example, prolonged Alcohol Dependence may cause Alcohol Withdrawal Delirium, Alcohol Amnestic Disorder, or Alcohol Hallucinosis. Similarly, Hallucinogen Delusional Disorder may be a complication of chronic hallucinogen use. Complications of the specific intoxication states, such as traffic accidents and physical injury due to Alcohol Intoxication, have been noted in the Organic Mental Disorders section.

Frequently there is a deterioration in the general level of physical health. Malnutrition and a variety of other physical disorders may result from failure to maintain physical health by proper diet and adequate personal hygiene.

Use of contaminated needles for the intravenous administration of opioids, cocaine, and amphetamines can cause hepatitis, tetanus, vasculitis, septicemia, subacute bacterial endocarditis, embolic phenomena, or malaria. Materials used to "cut" the substances can cause toxic or allergic reactions. Use of cocaine by means of the intranasal route ("snorting") sometimes results in erosion of the nasal septum.

Physical complications of chronic Alcohol Dependence include hepatitis, cirrhosis, peripheral neuropathy, and gastritis. In addition, chronic Alcohol Dependence increases the risk and seriousness of heart disease, pneumonia, tuberculosis, and neurological disorders. The long-term potential for respiratory disorder in chronic cannabis use is controversial. The long-term physical complications of chronic and heavy tobacco use are discussed on p. 177.

Depressive symptoms are a frequent complication of Substance Use Disorders, and partly account for the high rate of suicide by individuals with Substance Dependence. Suicide associated with alcohol and other substances can occur in both intoxicated and sober states.

Predisposing factors. Personality Disorders, particularly Antisocial Personality Disorder, predispose to the development of Substance Use Disorders.

Prevalence. Most of the Substance Use Disorders are common, especially those associated with alcohol and tobacco. Others, such as Opioid Abuse, are rare. For example, about 16% of the American public report *some* problem associated with alcohol within the past three years, and about 4% report more than trivial problems. In some economically deprived urban communities, Opioid Abuse and Dependence are widespread.

Sex ratio. Subtance Use Disorders are diagnosed more commonly in men than in women.

Differential diagnosis. Nonpathological substance use for recreational or medical purposes is not associated with impairment in social or occupational functioning or a pathological pattern of use.

Repeated episodes of substance-induced intoxication are almost invariably present in Substance Abuse or Dependence, although for some substances it is possible to develop dependence without ever exhibiting frank intoxication (e.g., alcohol). Furthermore, substance-induced intoxication as an isolated episode not involving either abuse or dependence is common.

There are now methods to detect the presence of alcohol, barbiturates and similarly acting sedatives and hypnotics, opioids, cocaine, and amphetamines in serum or urine. In some cases the tests indicate that an individual who thinks he or she has been using one substance, such as cocaine, has in fact been taking something else, such as amphetamine crystals.

A test dose may be used to establish tolerance to barbiturates by administering 200 mg of a short-acting barbiturate (usually pentobarbital) hourly until early signs of intoxication appear. The total amount of barbiturate required to produce these signs of intoxication is multiplied by a factor of three, giving an approximation of the individual's daily tolerance level to barbiturates.

When Opioid Dependence is suspected, signs and symptoms of Opioid Withdrawal may be precipitated by the subcutaneous administration of 0.4 mg of naloxone, an opioid antagonist. (This should not be administered to individuals with a history of cardiac disease or coronary insufficiency.)

305.0x Alcohol Abuse

303.9x Alcohol Dependence

For a description of Alcohol Intoxication, Alcohol Withdrawal, and the other Alcohol Organic Mental Disorders, see Alcohol-induced Organic Mental Disorders, p. 129.

The essential feature of Alcohol Abuse is a pattern of pathological use for at least a month that causes impairment in social or occupational functioning.

The essential features of Alcohol Dependence are either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol, and either tolerance or withdrawal. Alcohol Dependence has also been called Alcoholism.

Course. When abuse or dependence develops, it is usually within the first five years after regular drinking is established. Heavy drinking in adolescence (before age 16) is particularly likely to be associated with later problems.

Although Alcohol Dependence and Abuse can continue into old age, they may remit with aging, sometimes in response to the development of physical complications. Occasional drinking with rare or no episodes of intoxication *does* occur in some persons with a clear prior history of Alcohol Dependence. Therefore, drinking that is currently moderate should not be considered evidence for the absence of Alcohol Dependence in the past.

There are three main patterns of chronic pathological alcohol use. The first is regular daily intake of large amounts; the second is regular heavy drinking limited to weekends. These two patterns are included in the fifth-digit subtype "Continuous." The third pattern is long periods of sobriety interspersed with binges of daily heavy drinking lasting for weeks or months. This pattern corresponds to the fifth-digit subtype "Episodic."

Familial pattern. Alcohol Abuse and Dependence are more common among family members than in the general population. Evidence of a genetic factor is the increased prevalence of Alcohol Dependence in the early-adopted offspring of parents with the disorder.

Diagnostic criteria for Alcohol Abuse

A. *Pattern of pathological alcohol use:* need for daily use of alcohol for adequate functioning; inability to cut down or stop drinking; repeated efforts to control or reduce excess drinking by "going on the wagon" (periods of temporary abstinence) or restricting drinking to certain times of the day; binges (remaining intoxicated throughout the day for at least two days); occasional consumption of a fifth of spirits (or its equivalent in wine or beer); amnesic periods for events occurring while intoxicated (blackouts); continuation of drinking despite a serious physical disorder that the individual knows is exacerbated by alcohol use; drinking of non-beverage alcohol.

B. *Impairment in social or occupational functioning due to alcohol use:* e.g., violence while intoxicated, absence from work, loss of job, legal difficulties (e.g., arrest for intoxicated behavior, traffic accidents while intoxicated), arguments or difficulties with family or friends because of excessive alcohol use.

C. Duration of disturbance of at least one month.

Diagnostic criteria for Alcohol Dependence

A. Either a pattern of pathological alcohol use or impairment in social or occupational functioning due to alcohol use:

Pattern of pathological alcohol use: need for daily use of alcohol for adequate functioning; inability to cut down or stop drinking; repeated efforts to control or reduce excess drinking by "going on the wagon" (periods of temporary abstinence) or restricting drinking to certain times of the day; binges (remaining intoxicated throughout the day for at least two days); occasional consumption of a fifth of spirits (or its equivalent in wine or beer); amnesic periods for events occurring while intoxicated (blackouts); continuation of drinking despite a serious physical disorder that the individual knows is exacerbated by alcohol use; drinking of non-beverage alcohol.

Impairment in social or occupational functioning due to alcohol use: e.g., violence while intoxicated, absence from work, loss of job, legal difficulties (e.g., arrest for intoxicated behavior, traffic accidents while intoxicated), arguments or difficulties with family or friends because of excessive alcohol use.

B. Either tolerance or withdrawal:

Tolerance: need for markedly increased amounts of alcohol to achieve the desired effect, or markedly diminished effect with regular use of the same amount.

Withdrawal: development of Alcohol Withdrawal (e.g., morning "shakes" and malaise relieved by drinking) after cessation of or reduction in drinking (p. 133).

305.4x Barbiturate or Similarly Acting Sedative or Hypnotic Abuse

304.1x Barbiturate or Similarly Acting Sedative or Hypnotic Dependence

See Barbiturate or Similarly Acting Sedative or Hypnotic Organic Mental Disorders (p. 139) for a discussion of the substances included in this class, usual routes of administration, and a description of Barbiturate or Similarly Acting Sedative or Hypnotic Intoxication, Withdrawal, and Amnestic Disorder.

The essential feature of Barbiturate or Similarly Acting Sedative or Hypnotic Abuse is a pattern of pathological use for at least one month that

causes impairment in social or occupational functioning. The essential feature of Barbiturate or Similarly Acting Sedative or Hypnotic Dependence is either tolerance or withdrawal.

There are two patterns of development of dependence and abuse. In one, the individual has originally obtained the substance by prescription from a physician for insomnia, but has gradually increased the dose and frequency of use on his or her own. At first this increase is intended for sleep, but the individual then discovers that adjusted doses of the substance during the day seem to help in coping with daily living problems through relief of tension and anxiety. Individuals with this pattern are more apt to be from a middle-class background, between ages 30-60, and female. The other pattern involves individuals who are apt to be males in their teens or early 20s who, with a group of peers, use substances obtained from illegal sources. The initial objective is to attain a "high" or euphoria, or to counteract the stimulant effects of amphetamines.

Course. The most common course is heavy daily use that results in dependence. A significant number of individuals with dependence eventually stop using the substance, and demonstrate a permanent recovery, even from the physical complications of the disorder.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Abuse

A. *Pattern of pathological use:* inability to cut down or stop use; intoxication throughout the day; frequent use of the equivalent of 600 mg or more of secobarbital or 60 mg or more of diazepam; amnesic periods for events that occurred while intoxicated.

B. *Impairment in social or occupational functioning due to substance use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than a single arrest due to possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

Diagnostic criteria for Barbiturate or Similarly Acting Sedative or Hypnotic Dependence

Either tolerance or withdrawal:

Tolerance: need for markedly increased amounts of the substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount.

Withdrawal: development of Barbiturate or Similarly Acting Sedative or Hypnotic Withdrawal (p. 140) after cessation of or reduction in substance use.

305.5x Opioid Abuse

304.0x Opioid Dependence

See Opioid Organic Mental Disorders (p. 142) for a discussion of the substances included in this class, usual routes of administration, and a description of Opioid Intoxication and Withdrawal.

The essential feature of Opioid Abuse is a pattern of pathological use for at least one month that causes impairment in social or occupational functioning.

The essential feature of Opioid Dependence is either tolerance or withdrawal.

Course. Opioid Abuse and Dependence are generally preceded by a period of "polydrug use," which may involve tobacco, alcohol, marijuana, sedative-hypnotics, prescription and nonprescription cough syrups, hallucinogens, or amphetamines. The use of these other substances usually continues after the use of opioids is established. Once a pattern of Opioid Dependence is established, substance procurement and use usually dominates the individual's life.

Approximately half of the individuals who engage in Opioid Abuse go on to develop Opioid Dependence. Once Opioid Dependence is established, the course is a function of the context of the addiction. For example, the vast majority of persons who became dependent on heroin in Vietnam did not return to their addiction when back in the United States. In contrast, it is believed that most individuals who become dependent on opioids in the United States become involved in a chronic behavioral disorder, marked by remissions while in treatment or prison or when the substance is scarce and relapses on returning to a familiar environment where these substances are available and friends or colleagues use these substances. In the United States, in this century, persons with Opioid Dependence have a high annual death rate (approximately 10 per 1,000) because of the physical complications of the disorder and a lifestyle often associated with violence. Among those who survive, increased abstinence is found with the passage of years, with final cessation of dependence an average of about nine years after its onset.

Diagnostic criteria for Opioid Abuse

A. *Pattern of pathological use:* inability to reduce or stop use; intoxication throughout the day; use of opioids nearly every day for at least a month; episodes of opioid overdose (intoxication so severe that respiration and consciousness are impaired).

B. *Impairment in social or occupational functioning due to opioid use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

Diagnostic criteria for Opioid Dependence

Either tolerance or withdrawal:

Tolerance: need for markedly increased amounts of opioid to achieve the desired effect, or markedly diminished effect with regular use of the same amount.

Withdrawal: development of Opioid Withdrawal (p. 144) after cessation of or reduction in substance use.

305.6x Cocaine Abuse

See Cocaine Organic Mental Disorders (p. 145) for a discussion of the usual routes of administration and a description of Cocaine Intoxication. Since only transitory withdrawal symptoms occur after cessation of or reduction in prolonged use, a separate category of dependence on cocaine is not included.

The essential feature of Cocaine Abuse is a pathological pattern of use for at least one month that causes impairment in social or occupational functioning.

Course. The development of Cocaine Abuse may take two to eight months of cocaine use. Paranoid ideation, suspiciousness, and ritualistic behavior generally occur late in the course of abuse. Although habitual use has lasted 10 to 15 years in some persons, Cocaine Abuse does not have as prolonged a course as is usually the case with Barbiturate and Opioid Abuse.

Diagnostic criteria for Cocaine Abuse

A. *Pattern of pathological use:* inability to reduce or stop use; intoxication throughout the day; episodes of cocaine overdose (intoxication so severe that hallucinations and delusions occur in a clear sensorium).

B. *Impairment in social or occupational functioning due to cocaine use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

305.7x Amphetamine or Similarly Acting Sympathomimetic Abuse

304.4x Amphetamine or Similarly Acting Sympathomimetic Dependence

See Amphetamine or Similarly Acting Sympathomimetic Organic Mental Disorders (p. 147) for a discussion of the substances included in this class, usual routes of administration, and a description of Amphetamine or Similarly Acting Sympathomimetic Intoxication, Delirium, Delusional Disorder, and Withdrawal.

The essential feature of Amphetamine or Similarly Acting Sympathomimetic Abuse is a pattern of pathological use for at least a month that causes impairment in social or occupational functioning. The usual pattern is "runs" of daily use for 10 to 14 days at a time. The essential feature of Amphetamine or Similarly Acting Sympathomimetic Dependence is either tolerance or withdrawal.

Course. See Cocaine Abuse, p. 173.

Diagnostic criteria for Amphetamine or Similarly Acting Sympathomimetic Abuse

A. *Pattern of pathological use:* inability to reduce or stop use; intoxication throughout the day; use of substance nearly every day for at least one month; episodes of either Amphetamine or Similarly Acting Sympathomimetic Delusional Disorder or Amphetamine or Similarly Acting Sympathomimetic Delirium.

B. *Impairment in social or occupational functioning due to amphetamine or similarly acting sympathomimetic use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

Diagnostic criteria for Amphetamine or Similarly Acting Sympathomimetic Dependence

Either tolerance or withdrawal:

Tolerance: need for markedly increased amounts of substance to achieve the desired effect, or markedly diminished effect with regular use of the same amount.

Withdrawal: development of Amphetamine or Similarly Acting Sympathomimetic Withdrawal (p. 150) after cessation of or reduction in substance use.

305.9x Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Abuse

See Phencyclidine or Similarly Acting Arylcyclohexylamine Organic Mental Disorders (p. 150) for a discussion of the substances included in this class, usual routes of administration, and a description of Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Intoxication, Delirium, and Mixed Organic Mental Disorder.

The essential feature of Phencyclidine or Similarly Acting Arylcyclohexylamine Abuse is a pattern of pathological use for at least a month that causes impairment in social or occupational functioning.

Because no clear withdrawal syndrome or tolerance to this substance has been produced experimentally or observed clinically, a category for dependence is not included.

Course. See Cocaine Abuse, p. 173.

Diagnostic criteria for Phencyclidine (PCP) or Similarly Acting Arylcyclohexylamine Abuse

A. *Pattern of pathological use:* intoxication throughout the day; episodes

of Phencyclidine or Similarly Acting Arylcyclohexylamine Delirium or Mixed Organic Mental Disorder.

B. *Impairment in social or occupational functioning due to substance use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

305.3x Hallucinogen Abuse

See Hallucinogen Organic Mental Disorders (p. 153) for a discussion of the substances included in this class, usual route of administration, and a description of Hallucinogen Intoxication, Delusional Disorder, and Affective Disorder.

The essential feature of Hallucinogen Abuse is a pattern of pathological use for at least one month that causes impairment in social or occupational functioning.

Because no clear withdrawal syndrome has been produced experimentally or observed clinically, a category for dependence is not included.

Course. The course is unpredictable and is probably related to the nature of the underlying pathology that played a role in the onset of use. Most individuals rapidly resume their former life-style after only a brief period of abuse.

Diagnostic criteria for Hallucinogen Abuse

A. *Pattern of pathological use:* inability to reduce or stop use; intoxication throughout the day (possible only with some hallucinogens); episodes of Hallucinogen Delusional Disorder or Hallucinogen Affective Disorder.

B. *Impairment in social or occupational functioning due to hallucinogen use:* e.g., fights, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the illegal substance).

C. Duration of disturbance of at least one month.

305.2x Cannabis Abuse

304.3x Cannabis Dependence

See Cannabis Organic Mental Disorders (p. 156) for a discussion of the substances included in this class, usual routes of administration, and a description of Cannabis Intoxication and Delusional Disorder.

The essential feature of Cannabis Abuse is a pattern of pathological use

for at least a month that causes impairment in social or occupational functioning. The essential features of Cannabis Dependence are impairment in social or occupational functioning due to cannabis use, and tolerance (withdrawal has not been conclusively demonstrated). The existence and significance of tolerance (Cannabis Dependence) with regular heavy use of cannabis are controversial.

Course. Many users stop or decrease their use of cannabis spontaneously or when impairment in functioning develops.

Diagnostic criteria for Cannabis Abuse

A. *Pattern of pathological use:* intoxication throughout the day; use of cannabis nearly every day for at least a month; episodes of Cannabis Delusional Disorder.

B. *Impairment in social or occupational functioning due to cannabis use:* e.g., marked loss of interest in activities previously engaged in, loss of friends, absence from work, loss of job, or legal difficulties (other than due to a single arrest for possession, purchase, or sale of the substance).

C. Duration of disturbance of at least one month.

Diagnostic criteria for Cannabis Dependence

A. Either a pattern of pathological use or impairment in social or occupational functioning due to cannabis use.

Pattern of pathological use: intoxication throughout the day; use of cannabis nearly every day for at least a month; episodes of Cannabis Delusional Disorder.

Impairment in social or occupational functioning due to cannabis use: e.g., marked loss of interest in activities previously engaged in, loss of friends, absence from work, loss of job, or legal difficulties (other than a single arrest due to possession, purchase, or sale of an illegal substance).

B. *Tolerance:* need for markedly increased amounts of cannabis to achieve the desired effect or markedly diminished effect with regular use of the same amount.

305.1x Tobacco Dependence

The essential features are continuous use of tobacco for at least one month with either (1) unsuccessful attempts to stop or significantly reduce the amount of tobacco use on a permanent basis, (2) the development of Tobacco Withdrawal, or (3) the presence of a serious physical disorder (e.g., respiratory or cardiovascular disease) that the individual knows is exacerbated by tobacco use. In practice this diagnosis will be given only when either the individual is seeking professional help to stop smoking, or, in the judgment of the diagnosti-

cian, the use of tobacco is seriously affecting the individual's physical health. It should also be noted that a heavy smoker who has never tried to stop smoking, who has never developed Tobacco Withdrawal, and who has no tobacco-related serious physical disorder, according to the criteria in this manual, does not have the disorder of Tobacco Dependence, even though physiologically the individual is almost certainly dependent on tobacco.

At present, the most common form of Tobacco Dependence is associated with the inhalation of cigarette smoke. Pipe and cigar smoking, the use of snuff, and the chewing of tobacco are less likely to lead to Tobacco Dependence for several reasons. First of all, the probability of developing serious health complications is lower than with cigarette smoking, probably because relatively little smoke is inhaled; consequently, there is less distress arising from health concerns about the need to take the substance repeatedly. Second, the more rapid onset of nicotine effects with cigarette smoking leads to a more intensive habit pattern that is more difficult to give up owing to the frequency of reinforcement or the greater physical dependence on nicotine.

In recent years the evidence that tobacco use predisposes to a variety of serious physical disorders has led many individuals who are heavy smokers to attempt to give up the habit. However, many are unable to stop at all or, if they do, often resume tobacco use within a matter of months.

The difficulty in giving up tobacco use on a long-term basis, particularly with cigarettes, may be due to the unpleasant nature of the withdrawal syndrome, the highly overlearned nature of the habit that stems from the repeated effects of nicotine, which rapidly follow the inhalation of cigarette smoke (75,000 puffs per year for a pack-a-day smoker), and the likelihood that a desire to use tobacco is elicited by environmental cues, such as the ubiquitous presence of other smokers and the widespread availability of cigarettes.

When efforts to give up smoking are made, Tobacco Withdrawal may develop. (For a discussion of Tobacco Withdrawal, see p. 159.)

The most common tobacco-related serious physical disorders are bronchitis, emphysema, coronary artery disease, peripheral vascular disease, and a variety of cancers. The diagnostician must assess the role of tobacco use as an etiological or exacerbating factor for the particular individual after considering both individual circumstances and the latest available scientific information. If the individual with a serious case of one of the tobacco-related physical disorders continues to use tobacco, despite awareness of its harmful effects, a reasonable inference can be made that the individual is dependent on tobacco.

Associated features. Individuals with this disorder are frequently distressed at their inability to stop tobacco use, particularly when they have serious physical symptoms that are aggravated by tobacco use. Some individuals who are dependent on tobacco may have difficulty remaining in social or occupational situations that prohibit smoking.

Age at onset. Tobacco Dependence usually begins in late adolescence or early adult life.

Course. The course of Tobacco Dependence is variable. Some individuals repeatedly attempt to give up tobacco use without success. Others have a brief course, in that when they experience concern about tobacco use they make a prompt effort to stop and are successful in total cessation, although in many cases they may experience a period of Tobacco Withdrawal lasting from days to weeks (see p. 159). Studies of treatment outcome suggest that the relapse rate is greater than 50% in the first six months, and approximately 70% within the first twelve months. After a year's abstinence subsequent relapse is unlikely.

Impairment. Since tobacco use rarely causes any identifiable state of intoxication as does alcohol, there is no impairment in social or occupational functioning as an immediate and direct consequence of tobacco use.

Prevalence and sex ratio. A large proportion of the adult population of the United States uses tobacco, the prevalence among men being greater than that among women. Among teenage smokers, boys are affected approximately as often as girls. The prevalence of Tobacco Dependence as defined here is not known. Some individuals give up smoking as they grow older without ever meeting the criteria for the disorder. However, since surveys have shown that approximately 50% of smokers express a desire to be able to stop and are unable to do so, and since serious physical disorders that are aggravated by smoking are common, Tobacco Dependence is obviously widespread.

Familial pattern. Cigarette smoking among family members of individuals with Tobacco Dependence is more common than in the general population. However, the evidence for a genetic factor is extremely weak.

Differential diagnosis. The major differential diagnostic problems will be to determine whether or not a particular physical disorder, in an individual who is a heavy smoker, is exacerbated by tobacco use, and how long a period of abstinence from tobacco use justifies the judgment that the disorder is no longer present or is in a state of remission.

Diagnostic criteria for Tobacco Dependence

A. Continuous use of tobacco for at least one month.

B. At least one of the following:

(1) serious attempts to stop or significantly reduce the amount of tobacco use on a permanent basis have been unsuccessful

(2) attempts to stop smoking have led to the development of Tobacco Withdrawal (see p. 159)

(3) the individual continues to use tobacco despite a serious physical disorder (e.g., respiratory or cardiovascular disease) that he or she knows is exacerbated by tobacco use

305.9x Other, Mixed, or Unspecified Substance Abuse

Other Substance Abuse should be recorded if a substance abused cannot be classified in any of the categories noted above, e.g., glue (inhalants), amyl nitrite.

Mixed Substance Abuse should be noted when the substances abused are from more than one nonalcoholic substance category, e.g., amphetamines and barbiturates. This category should be used only when the specific substances cannot be identified or when the abuse involves so many substances that the clinician prefers to indicate a combination of substances rather than list each specific substance.

Unspecified Substance Abuse should be recorded when a substance abused is unknown.

304.6x Other Specified Substance Dependence

This category should be used when the individual is dependent on a substance that cannot be classified in any of the previous categories, e.g., codeine or corticosteroids.

304.9x Unspecified Substance Dependence

This diagnosis can be used as an initial diagnosis in cases in which the specific substance is not yet known.

304.7x Dependence on a Combination of Opioid and Other Nonalcoholic Substances

This category should be used when the individual is dependent on both an opioid and a nonopioid nonalcoholic substance. An example might be dependence on both heroin and barbiturates. This category should be used only when the specific substances cannot be identified or when the dependence involves so many substances that the clinician prefers to indicate a combination of substances rather than list each specific substance.

304.8x Dependence on a Combination of Substances, Excluding Opioids and Alcohol

This category should be used when the individual is dependent on two or more nonopioid nonalcoholic substances. An example might be dependence on both amphetamines and barbiturates. This category should be used only when the specific substances cannot be identified or when the dependence involves so many substances that the clinician prefers to indicate a combination of substances rather than list each specific substance.

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Schizophrenic Disorders

The essential features of this group of disorders* are: the presence of certain psychotic features during the active phase of the illness, characteristic symptoms involving multiple psychological processes, deterioration from a previous level of functioning, onset before age 45, and a duration of at least six months. The disturbance is not due to an Affective Disorder or Organic Mental Disorder. At some phase of the illness Schizophrenia always involves delusions, hallucinations, or certain disturbances in the form of thought.

The limits of the concept of Schizophrenia are unclear. Some approaches to defining the concept have emphasized the tendency toward a deteriorating course (Kraepelin), underlying disturbances in certain psychological processes (Bleuler), or pathognomonic symptoms (Schneider). In this manual the concept is not limited to illnesses with a deteriorating course, although a minimal duration of illness is required since the accumulated evidence suggests that illnesses of briefer duration (here called Schizophreniform Disorder) are likely to have different external correlates, such as family history and likelihood of recurrence. The approach taken here excludes illnesses without overt psychotic features, which have been referred to as Latent, Borderline, or Simple Schizophrenia.† Such cases are likely to be diagnosed in this manual as having a Personality Disorder such as Schizotypal Personality Disorder. Illnesses with onset after mid-adult life are also excluded, and may be classified as Atypical Psychosis. Furthermore, individuals who develop a depressive or manic syndrome for an extended period relative to the duration of certain psychotic features or before the psychotic features appear, are not classified as having Schizophrenia but rather as having either an Affective or Schizoaffective Disorder. Thus, this manual utilizes clinical criteria that include both a minimum duration and a characteristic symptom picture to identify a group of conditions that has validity in terms of differential response to somatic therapy; presence of a familial pattern; and a tendency toward onset in early adult life, recurrence and deterioration in social and occupational functioning.

Deterioration from a previous level of functioning. Schizophrenia always involves deterioration from a previous level of functioning during some phase of the illness in such areas as work, social relations, and self-care. Family and friends often observe that the person is "not the same."

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* Although Schizophrenia is most likely a group of disorders of differing etiologies, common usage refers to "Schizophrenia" rather than the technically more accurate term, Schizophrenic Disorders.

† The clinician wishing to use these non-DSM-III diagnoses may do so since they are included in ICD-9-CM (p.399).

Characteristic symptoms involving multiple psychological processes. Invariably there are characteristic disturbances in several of the following areas: content and form of thought, perception, affect, sense of self, volition, relationship to the external world, and psychomotor behavior. It should be noted that no single feature is invariably present or seen only in Schizophrenia.

Content of thought. The major disturbance in the content of thought involves delusions that are often multiple, fragmented, or bizarre (i.e., patently absurd, with no possible basis in fact). Simple persecutory delusions involving the belief that others are spying on, spreading false rumors about, or planning harm to the individual are common. Delusions of reference, in which events, objects, or other people are given particular and unusual significance, usually of a negative or pejorative nature, are also common. For example, the individual may be convinced that a television commentator is mocking him.

Certain delusions are far more common in this disorder than in other psychotic disorders. These include, for instance, the belief or experience that one's thoughts, as they occur, are broadcast from one's head to the external world so that others can hear them (thought broadcasting); that thoughts that are not one's own are inserted into one's mind (thought insertion); that thoughts have been removed from one's head (thought withdrawal); or that one's feelings, impulses, thoughts, or actions are not one's own but are imposed by some external force (delusions of being controlled). Less commonly, somatic, grandiose, religious, and nihilistic delusions are seen. Overvalued ideas may occur (e.g., preoccupation with the special significance of certain dietary habits), or markedly illogical thinking (e.g., thinking that contains clear internal contradictions or in which conclusions are reached that are clearly erroneous, given the initial premises).

Form of thought. A disturbance in the form of thought is often present. This has been referred to as "formal thought disorder," and is distinguished from a disorder in the content of thought. The most common example of this is loosening of associations, in which ideas shift from one subject to another completely unrelated or only obliquely related subject, without the speaker showing any awareness that the topics are unconnected. Statements that lack a meaningful relationship may be juxtaposed, or the individual may shift idiosyncratically from one frame of reference to another. When loosening of associations is severe, incoherence may occur, that is, speech may become incomprehensible. There may also be poverty of content of speech, in which speech is adequate in amount but conveys little information because it is vague, overly abstract or overly concrete, repetitive, or stereotyped. The listener can recognize this disturbance by noting that little if any information has been conveyed although the individual has spoken at some length. Less common disturbances include neologisms, perseveration, clanging, and blocking.

Perception. The major disturbances in perception are various forms of hallucination. Although these occur in all modalities, by far the most common are auditory, frequently involving voices the individual perceives as coming

from outside the head. The voices may be familiar, and often make insulting statements. The voices may be single or multiple. Voices speaking directly to the individual or commenting on his or her ongoing behavior are particularly characteristic. Command hallucinations may be obeyed, at times creating danger for the individual or others. Occasionally, the auditory hallucinations are of sounds rather than voices. Tactile hallucinations may be present, and typically involve electrical, tingling, or burning sensations. Somatic hallucinations, such as the sensation of snakes crawling inside the abdomen, are occasionally experienced. Visual, gustatory, and olfactory hallucinations also occur, but with less frequency, and, in the absence of auditory hallucinations, always raise the possibility of an Organic Mental Disorder.

Other perceptual abnormalities include sensations of bodily change and hypersensitivity to sound, sight, and smell.

Affect. The disturbance often involves blunting, flattening, or inappropriateness of affect. In blunted affect there is severe reduction in the intensity of affective expression. In flat affect there are virtually no signs of affective expression; the voice is usually monotonous and the face, immobile. The individual may complain that he or she no longer responds with normal emotional intensity or, in extreme cases, no longer has feelings. In inappropriate affect, the affect is clearly discordant with the content of the individual's speech or ideation. For example, while discussing being tortured by electrical shocks, an individual with Schizophrenia, Paranoid Type, laughs or smiles. Sudden and unpredictable changes in affect involving inexplicable outbursts of anger may occur.

Although these affective disturbances are almost invariably present, their usefulness in making the diagnosis is limited because their presence is often difficult to judge except when present in extreme form. Furthermore, the antipsychotic drugs have effects that may appear similar to the affective blunting and flattening seen in Schizophrenia.

Sense of self. The sense of self that gives the normal person a feeling of individuality, uniqueness, and self-direction is frequently disturbed. This is sometimes referred to as a loss of ego boundaries and is frequently manifested by extreme perplexity about one's own identity and the meaning of existence, or by some of the specific delusions described above, particularly those involving control by an outside force.

Volition. Nearly always there is some disturbance in self-initiated, goal-directed activity, which may grossly impair work or other role functioning. This may take the form of inadequate interest or drive or inability to follow a course of action to its logical conclusion. Pronounced ambivalence regarding alternative courses of action can lead to near cessation of goal-directed activity.

Relationship to the external world. Frequently there is a tendency to withdraw from involvement with the external world and to become preoccupied with egocentric and illogical ideas and fantasies in which objective facts are obscured,

distorted, or excluded. When severe, this condition has been referred to as "autism." Family members or friends frequently comment that the individual seems preoccupied, in his or her own world, and emotionally detached from others.

Psychomotor behavior. Various disturbances in psychomotor behavior are observed, particularly in the chronically severe and acutely florid forms of the disorder. A marked decrease may occur in reactivity to the environment, with a reduction in spontaneous movements and activity. In extreme cases the individual appears unaware of the nature of the environment (as in catatonic stupor); may maintain a rigid posture resisting efforts to be moved (as in catatonic rigidity); may make apparently purposeless and stereotyped, excited motor movements not influenced by external stimuli (as in catatonic excitement); may voluntarily assume inappropriate or bizarre postures (as in catatonic posturing); or resist and actively counteract instructions or attempts to be moved (as in catatonic negativism). In addition, mannerisms, grimacing, or waxy flexibility may be present.

Associated features. Almost any symptom can occur as an associated feature. The individual may appear perplexed, disheveled, or eccentrically groomed or dressed. Abnormalities of psychomotor activity—e.g., pacing, rocking, or apathetic immobility—are common. Frequently, there is poverty of speech, that is, a restriction in the amount of spontaneous speech, so that replies to questions tend to be brief, concrete, and unelaborated. Ritualistic or stereotyped behavior associated with magical thinking often occurs. Dysphoric mood is common, and may take the form of depression, anxiety, anger, or a mixture of these. Depersonalization, derealization, ideas of reference, and illusions are often present, as are hypochondriacal concerns that may or may not be delusional. Typically, no disturbance in sensorium is evident, although during a period of exacerbation the individual may be confused and even disoriented, or have memory impairment.

Age at onset. Onset is usually during adolescence or early adulthood.

Course. As noted previously, the diagnosis of Schizophrenia requires that continuous signs of the illness have lasted for at least six months which always includes an active phase of psychotic symptoms, and may or may not include prodromal or residual phases.

The development of the active phase of the illness is usually preceded by a *prodromal phase* in which there is a clear deterioration in a previous level of functioning. This phase is characterized by social withdrawal, impairment in role functioning, peculiar behavior, impairment in personal hygiene and grooming, blunted or inappropriate affect, disturbances in communication, bizarre ideation, and unusual perceptual experiences. A change in personality is often noted by friends or relatives. The length of this prodromal phase is extremely variable, and its onset may be difficult to date accurately. The prognosis is especially poor when the prodromal phase has taken an insidious, downhill course over many years.

During the *active phase* psychotic symptoms—e.g., delusions, hallucinations, loosening of associations, incoherence, poverty of content of speech, markedly illogical thinking, and behavior that is grossly disorganized or catatonic—are prominent. The specific psychotic symptoms are noted in criterion A of the diagnostic criteria (p. 188). The onset of the active phase, either initially or as an exacerbation of a preexisting active phase, is often associated with a psychosocial stressor.

Usually a *residual phase* follows the active phase of the illness. The clinical picture of this phase is similar to that of the prodromal phase, although affective blunting or flattening and impairment in role functioning tend to be more common in the residual phase. During the residual phase some of the psychotic symptoms, such as delusions or hallucinations, may persist, but are no longer accompanied by strong affect.

A complete return to premorbid functioning is unusual—so rare, in fact, that some clinicians would question the diagnosis. However, there is always the *possibility* of full remission or recovery, although its frequency is unknown. The most common course is one of acute exacerbations with increasing residual impairment between episodes.

Numerous studies have indicated a group of factors associated with good prognosis: absence of premorbid personality disturbance, adequate premorbid social functioning, precipitating events, abrupt onset, onset in mid-life, a clinical picture that involves confusion, and a family history of Affective Disorder.

Because a knowledge of course is very important for planning treatment, and because differences in course may reflect fundamental differences among Schizophrenic Disorders, a separate digit is provided for coding the course as Subchronic, Chronic, Subchronic with Acute Exacerbation, Chronic with Acute Exacerbation, or In Remission (for criteria, see p. 192).

Since a six-month duration of illness is required for the diagnosis, there is no acute subtype. (The DSM-III diagnosis of Schizophreniform Disorder is the nearest equivalent to the DSM-II and ICD-9-CM concepts of Acute Schizophrenic Episode. Frequently, an episode of Schizophreniform Disorder will persist for more than six months, in which case the diagnosis should be changed to Schizophrenia.)

Impairment. Invariably there is impairment in several areas of routine daily functioning, such as work, social relations, and self-care. Supervision may be required to ensure that nutritional and hygienic needs are met and to protect the individual from the consequences of poor judgment, cognitive impairment, or actions based on delusions or in response to hallucinations. Between episodes of illness there may be no disability or the extent of disability ranges from none to disability so severe that institutional care is required.

Complications. Although violent acts performed by individuals with this disorder often attract public attention, whether the frequency of such acts is greater than in the general population is not known. The life expectancy of individuals with Schizophrenia is shorter than that of the general population because of an increased suicide rate and death from a variety of other causes—

some, at least in the past, associated with institutional care. Other causes of death are associated with the economically deprived environments in which many individuals with this disorder live.

Premorbid personality. The premorbid personalities of individuals who develop Schizophrenia are often described as suspicious, introverted, withdrawn, or eccentric. Such individuals may meet the criteria for Paranoid, Schizoid, Schizotypal, or Borderline Personality Disorder. In such cases, since it can have prognostic significance, the Personality Disorder should be noted on Axis II, followed by the phrase "(Premorbid)."

Predisposing factors. The diagnosis is made more commonly among the lower socioeconomic groups. The reasons for this are unclear, but may involve downward social drift, lack of upward socioeconomic mobility, and high stress.

Certain patterns of family interaction have been hypothesized as predisposing to the development, onset, relapse or chronicity of Schizophrenia. The interpretation of the evidence supporting these hypotheses is controversial.

Prevalence. Studies in Europe and Asia, using a relatively narrow concept of Schizophrenia, have found a lifetime prevalence rate of from 0.2% to almost 1%. Studies done in the United States that have used broader criteria and surveyed urban populations have reported higher rates.

Sex ratio. The disorder is apparently equally common in males and in females.

Familial pattern. All investigators have found a higher prevalence of the disorder among family members. This includes studies in which the adopted offspring of individuals with Schizophrenia have been reared by parents who do not have Schizophrenia. Twin studies consistently show a higher concordance rate of Schizophrenia for monozygotic than dizygotic twins, and dizygotic twins have the same concordance rate as siblings who are not twins. However, being a monozygotic twin does not in itself predispose to the development of Schizophrenia. Although genetic factors have been proven to be involved in the development of the illness, the existence of a substantial discordance rate, even in monozygotic twins, indicates the importance of nongenetic factors.

Differential diagnosis. Organic Mental Disorders often present with symptoms that suggest Schizophrenia, such as delusions, hallucinations, incoherence, and blunted or inappropriate affect. In particular, **Organic Delusional Syndromes, such as those due to amphetamines or phencyclidine,** may cross-sectionally be identical in symptomatology with Schizophrenia. Even though an active phase of Schizophrenia may begin with confusion, the presence of disorientation or memory impairment strongly suggests an Organic Mental Disorder. (Of course, it is possible for an individual with Schizophrenia to have a superimposed Organic Mental Disorder.)

Paranoid Disorders are distinguished from Schizophrenia by the absence of prominent hallucinations, incoherence, loosening of associations, or bizarre delusions, such as delusions of being controlled or thought broadcasting.

In **Affective Disorders** there often are withdrawal and deterioration in functioning. These should not be mistaken for prodromal signs of Schizophrenia. In Affective Disorders the development of delusions or hallucinations follows a period of affective disturbance. For this reason the diagnosis of Schizophrenia is not made unless an affective syndrome, if present, developed *after* any psychotic symptoms or was brief in duration relative to the duration of the characteristic psychotic symptoms. The differential diagnosis of Schizophrenia from the psychotic forms of the Affective Disorders, particularly Bipolar Disorder, is of special importance because of the different long-term treatment implications. A manic episode with anger and paranoid delusions needs to be distinguished from Schizophrenia, Paranoid Type. However, an **Atypical Affective Disorder** or **Adjustment Disorder with Depressed Mood** may be superimposed on Schizophrenia, Residual Type. An example would be an individual with Schizophrenia, Residual Type, Chronic, who could develop a major depressive episode of several months' duration without any psychotic symptoms. In such a case both Schizophrenia and Atypical Depression should be diagnosed.

The diagnosis **Schizoaffective Disorder** should be made whenever the clinician is unable to make a differential diagnosis between Schizophrenia and Affective Disorder. Although no criteria for Schizoaffective Disorder are provided in this manual, several examples of clinical situations in which this diagnosis might be appropriate are given on p. 202.

In **Schizophreniform Disorder**, by definition the duration of the illness is less than six months. The cross-sectional symptom picture may be indistinguishable from Schizophrenia, but emotional turmoil and confusion are more likely to occur in Schizophreniform Disorder. It should be noted that the six-month duration of illness required for Schizophrenia refers to a continuous period of illness. Thus, an individual with several episodes of Schizophreniform Disorder from each of which there has been full recovery would not be diagnosed as having Schizophrenia merely because the total period of illness exceeded six months.

Atypical Psychosis is diagnosed when there is a nonaffective psychotic disorder but there is insufficient information to make a diagnosis of Schizophrenia. It is also diagnosed in those unusual instances in which one of the psychotic symptoms of Schizophrenia such as an encapsulated delusion of bodily change is present, but there is apparently no deterioration from a previous level of functioning.

In a **Pervasive Developmental Disorder**, the cross-sectional picture, particularly of the Residual State, may resemble Schizophrenia, Residual Type. However, there is no history of delusions, hallucinations, or incoherence.

In **Obsessive Compulsive Disorder, Hypochondriasis,** and more rarely **Phobic Disorder**, in order to account for the symptoms the individual may develop overvalued ideas that are difficult to distinguish from delusions. However, individuals with these disorders recognize, at least to some degree, that their symptoms and thinking are irrational, even if they are dominated by them.

In **Factitious Disorder with Psychological Symptoms**, "psychotic" symptoms are under the individual's voluntary control and are likely to be present only when the individual thinks he or she is being observed.

In **Personality Disorders, especially Schizotypal, Borderline, Schizoid,** and **Paranoid** types transient psychotic symptoms may occur. However, a return within hours or days to the usual level of functioning distinguishes these disorders from Schizophrenia. It is more difficult to distinguish severe forms of Paranoid and Schizotypal Personality Disorders from Schizophrenia because of the difficulty in determining whether the paranoid ideation is of delusional intensity and whether the oddities of communication and perception are severe enough to meet the criteria for Schizophrenia. Furthermore, it is often difficult to differentiate the prodromal phase of Schizophrenia from the manifestations of some of the Personality Disorders since both Personality Disorders and Schizophrenia usually develop during adolescence or early adult life.

Beliefs or experiences of members of religious or other subcultural groups may be difficult to distinguish from delusions or hallucinations. When such experiences are shared and accepted by a subcultural group they should not be considered evidence of psychosis.

In **Mental Retardation**, low level of social functioning, oddities of behavior, and impoverished affect and cognition all may suggest Schizophrenia. Both diagnoses should be made in the same individual only when there is certainty that the symptoms suggesting Schizophrenia, such as delusions or hallucinations, are definitely present and are not the result of difficulties in communication.

Diagnostic criteria for a Schizophrenic Disorder

A. At least one of the following during a phase of the illness:

(1) bizarre delusions (content is patently absurd and has *no* possible basis in fact), such as delusions of being controlled, thought broadcasting, thought insertion, or thought withdrawal

(2) somatic, grandiose, religious, nihilistic, or other delusions without persecutory or jealous content

(3) delusions with persecutory or jealous content if accompanied by hallucinations of any type

(4) auditory hallucinations in which either a voice keeps up a running commentary on the individual's behavior or thoughts, or two or more voices converse with each other

(5) auditory hallucinations on several occasions with content of more than one or two words, having no apparent relation to depression or elation

(6) incoherence, marked loosening of associations, markedly illogical thinking, or marked poverty of content of speech if associated with at least one of the following:

(a) blunted, flat, or inappropriate affect
(*b*) delusions or hallucinations
(*c*) catatonic or other grossly disorganized behavior

B. Deterioration from a previous level of functioning in such areas as work, social relations, and self-care.

C. Duration: Continuous signs of the illness for at least six months at some time during the person's life, with some signs of the illness at present. The six-month period must include an active phase during which there were symptoms from A, with or without a prodromal or residual phase, as defined below.

Prodromal phase: A clear deterioration in functioning before the active phase of the illness not due to a disturbance in mood or to a Substance Use Disorder and involving at least *two* of the symptoms noted below.

Residual phase: Persistence, following the active phase of the illness, of at least *two* of the symptoms noted below, not due to a disturbance in mood or to a Substance Use Disorder.

Prodromal or Residual Symptoms

(1) social isolation or withdrawal
(2) marked impairment in role functioning as wage-earner, student, or homemaker
(3) markedly peculiar behavior (e.g., collecting garbage, talking to self in public, or hoarding food)
(4) marked impairment in personal hygiene and grooming
(5) blunted, flat, or inappropriate affect
(6) digressive, vague, overelaborate, circumstantial, or metaphorical speech
(7) odd or bizarre ideation, or magical thinking, e.g., superstitiousness, clairvoyance, telepathy, "sixth sense," "others can feel my feelings," overvalued ideas, ideas of reference
(8) unusual perceptual experiences, e.g., recurrent illusions, sensing the presence of a force or person not actually present

Examples: Six months of prodromal symptoms with one week of symptoms from A; no prodromal symptoms with six months of symptoms from A; no prodromal symptoms with two weeks of symptoms from A and six months of residual symptoms; six months of symptoms from A, apparently followed by several years of complete remission, with one week of symptoms in A in current episode.

D. The full depressive or manic syndrome (criteria A and B of major depressive or manic episode), if present, developed after any psychotic symptoms, or was brief in duration relative to the duration of the psychotic symptoms in A.

E. Onset of prodromal or active phase of the illness before age 45.

F. Not due to any Organic Mental Disorder or Mental Retardation.

TYPES

The types reflect cross-sectional clinical syndromes. Some are less stable over time than others, and their prognostic and treatment implications are variable. The diagnosis of a particular type should be based on the predominant clinical picture that occasioned the evaluation or admission to clinical care.

295.1x Disorganized Type

The essential features are marked incoherence and flat, incongruous, or silly affect. There are no systematized delusions although fragmentary delusions or hallucinations in which the content is not organized into a coherent theme are common. Associated features include grimaces, mannerisms, hypochondriacal complaints, extreme social withdrawal, and other oddities of behavior.

This clinical picture is usually associated with extreme social impairment, poor premorbid personality, an early and insidious onset, and a chronic course without significant remissions.

In other classifications this type is termed Hebephrenic.

Diagnostic criteria for Disorganized Type

A type of Schizophrenia in which there are:

A. Frequent incoherence.

B. Absence of systematized delusions.

C. Blunted, inappropriate, or silly affect.

295.2x Catatonic Type

The essential feature is marked psychomotor disturbance, which may involve stupor, negativism, rigidity, excitement, or posturing. Sometimes there is rapid alternation between the extremes of excitement and stupor. Associated features include stereotypies, mannerisms, and waxy flexibility. Mutism is particularly common.

During catatonic stupor or excitement the individual needs careful supervision to avoid hurting self or others, and medical care may be needed because

of malnutrition, exhaustion, hyperpyrexia, or self-inflicted injury.

Although this type was very common several decades ago, it is now rare in Europe and North America.

Diagnostic criteria for Catatonic Type
A type of Schizophrenia dominated by any of the following:

(1) catatonic stupor (marked decrease in reactivity to environment and/or reduction of spontaneous movements and activity) or mutism
(2) catatonic negativism (an apparently motiveless resistance to all instructions or attempts to be moved)
(3) catatonic rigidity (maintenance of a rigid posture against efforts to be moved)
(4) catatonic excitement (excited motor activity, apparently purposeless and not influenced by external stimuli)
(5) catatonic posturing (voluntary assumption of inappropriate or bizarre posture)

295.3x Paranoid Type

The essential features are prominent persecutory or grandiose delusions, or hallucinations with a persecutory or grandiose content. In addition, delusional jealousy may be present.

Associated features include unfocused anxiety, anger, argumentativeness, and violence. In addition, there may be doubts about gender identity or fear of being thought of as a homosexual, or being approached by homosexuals.

The impairment in functioning may be minimal if the delusional material is not acted upon, since gross disorganization of behavior is relatively rare. Similarly, affective responsiveness may be preserved. Often a stilted, formal quality, or extreme intensity in interpersonal interactions is noted.

The onset tends to be later in life than the other subtypes, and the features are more stable over time. If a biologically related family member of an individual who has this subtype also has Schizophrenia, there is some evidence that the subtype of the relative will also be paranoid.

Diagnostic criteria for Paranoid Type
A type of Schizophrenia dominated by one or more of the following:

(1) persecutory delusions
(2) grandiose delusions
(3) delusional jealousy
(4) hallucinations with persecutory or grandiose content

295.9x Undifferentiated Type

The essential features are prominent psychotic symptoms that cannot be classi-

fied in any category previously listed or that meet the criteria for more than one.

Diagnostic criteria for Undifferentiated Type

A. A type of Schizophrenia in which there are: Prominent delusions, hallucinations, incoherence, or grossly disorganized behavior.

B. Does not meet the criteria for any of the previously listed types or meets the criteria for more than one.

295.6x Residual Type

This category should be used when there has been at least one episode of Schizophrenia but the clinical picture that occasioned the evaluation or admission to clinical care is without prominent psychotic symptoms, though signs of the illness persist. Emotional blunting, social withdrawal, eccentric behavior, illogical thinking and loosening of associations are common. If delusions or hallucinations are present, they are not prominent and are not accompanied by strong affect.

The course of this type is either chronic or subchronic, since "acute exacerbation" by definition, involves prominent psychotic symptoms, and "in remission" implies no signs of the illness.

Diagnostic criteria for Residual Type

A. A history of at least one previous episode of Schizophrenia with prominent psychotic symptoms.

B. A clinical picture without any prominent psychotic symptoms that occasioned evaluation or admission to clinical care.

C. Continuing evidence of the illness, such as blunted or inappropriate affect, social withdrawal, eccentric behavior, illogical thinking, or loosening of associations.

Classification of course. The course of the illness is coded in the fifth digit:

(1) *Subchronic.* The time from the beginning of the illness, during which the individual began to show signs of the illness (including prodromal, active, and residual phases) more or less continuously, is less than two years but at least six months.

(2) *Chronic.* Same as above, but greater than two years.

(3) *Subchronic with Acute Exacerbation.* Reemergence of prominent psychotic symptoms in an individual with a subchronic course who has been in the residual phase of the illness.

(4) *Chronic with Acute Exacerbation.* Reemergence of prominent psychotic symptoms in an individual with a chronic course who has been in the residual phase of the illness.

(5) *In Remission.* This should be used when an individual with a history of Schizophrenia, now is free of all signs of the illness (whether or not on medication). The differentiation of Schizophrenia In Remission from no mental disorder requires consideration of the period of time since the last period of disturbance, the total duration of the disturbance, and the need for continued evaluation or prophylactic treatment.

When the course is noted as "in remission," the phenomenologic type should describe the last episode of Schizophrenia, e.g., 295.25 Schizophrenia, Catatonic Type, In Remission. When the phenomenology of the last episode is unknown, it should be noted as Undifferentiated.

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Paranoid Disorders

The essential features are persistent persecutory delusions or delusional jealousy, not due to any other mental disorder, such as a Schizophrenic, Schizophreniform, Affective, or Organic Mental Disorder. The Paranoid Disorders include Paranoia, Shared Paranoid Disorder, and Acute Paranoid Disorder.

The boundaries of this group of disorders and their differentiation from such other disorders as severe Paranoid Personality Disorder and Schizophrenia, Paranoid Type, are unclear.

The persecutory delusions may be simple or elaborate and usually involve a single theme or series of connected themes, such as being conspired against, cheated, spied upon, 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.

There may be only delusional jealousy ("conjugal paranoia"), in which an individual may become convinced without due cause, that his or her mate is unfaithful. Small bits of "evidence," such as disarrayed clothing or spots on the sheets, may be collected and used to justify the delusion.

Associated features. Common associated features include resentment and anger, which may lead to violence. Grandiosity and ideas or delusions of reference are common. Often there is social isolation, seclusiveness, or eccentricities of behavior. Suspiciousness, either generalized or focused on certain individuals, is common. Letter writing, complaining about various injustices, and instigation of legal action are frequent. These individuals rarely seek treatment, and often are brought for care by associates, relatives, or governmental agencies as a result of the individuals' angry or litigious activities.

Age at onset. Generally middle or late adult life.

Course. The course of Paranoia and Shared Paranoid Disorder is chronic with few, if any, exacerbations or periods of remission. The course of Acute Paranoid Disorder, by definition, is limited to six months' duration.

Impairment. Impairment in daily functioning is rare. Intellectual and occupational functioning are usually preserved, even when the disorder is chronic. Social and marital functioning, on the other hand, are often severely impaired.

Complications. None.

Predisposing factors. Immigration, emigration, deafness, and other severe

stresses may predispose to the development of a Paranoid Disorder. Individuals with Paranoid or Schizoid Personality Disorders may also have a greater likelihood of developing a Paranoid Disorder.

Prevalence. Paranoid Disorders are thought to be rare. However, Paranoia involving delusional jealousy may be more common.

Sex ratio and familial pattern. No information.

Differential diagnosis. In **Organic Delusional Syndromes**, particularly those induced by amphetamines, persecutory delusions are common.

In **Schizophrenia, Paranoid Type**, or **Schizophreniform Disorder**, there are certain symptoms, such as incoherence, marked loosening of associations, prominent hallucinations, and bizarre delusions (e.g., delusions of control, thought broadcasting, withdrawal, or insertion), that are not present in Paranoid Disorders. Although delusions that others are attempting to control the individual's behavior are common in both Paranoid and Schizophrenic Disorders, the experience of being controlled by alien forces suggests Schizophrenia or Schizophreniform Disorder. In addition, delusions in Schizophrenia are more likely to be fragmented and multiple rather than systematized, as in Paranoid Disorders.

In **Paranoid Personality Disorder** there may be paranoid ideation or pathological jealousy, but there are no delusions. Whenever an individual with a Paranoid Disorder has a preexisting Personality Disorder, including Paranoid Personality Disorder, the Personality Disorder should be listed on Axis II, followed by the phrase "Premorbid" in parentheses.

Diagnostic criteria for Paranoid Disorder

A. Persistent persecutory delusions or delusional jealousy.

B. Emotion and behavior appropriate to the content of the delusional system.

C. Duration of illness of at least one week.

D. None of the symptoms of criterion A of Schizophrenia (p. 188), such as bizarre delusions, incoherence, or marked loosening of associations.

E. No prominent hallucinations.

F. The full depressive or manic syndrome (criteria A and B of major depressive or manic episode, p. 213, and p. 208) is either not present, developed after any psychotic symptoms, or was brief in duration relative to the duration of the psychotic symptoms.

G. Not due to an Organic Mental Disorder.

297.10 Paranoia

The essential feature is the insidious development of a Paranoid Disorder with a permanent and unshakable delusional system accompanied by preservation of clear and orderly thinking. Frequently the individual considers himself or herself endowed with unique and superior abilities. Chronic forms of "conjugal paranoia" and Involutional Paranoid State should be classified here.

Diagnostic criteria for Paranoia

A. Meets the criteria for Paranoid Disorder (p. 196).

B. A chronic and stable persecutory delusional system of at least six months' duration.

C. Does not meet the criteria for Shared Paranoid Disorder.

297.30 Shared Paranoid Disorder

The essential feature is a persecutory delusional system that develops as a result of a close relationship with another person who already has a disorder with persecutory delusions. The delusions are at least partly shared. Usually, if the relationship with the other person is interrupted, the delusional beliefs will diminish or disappear. In the past this disorder has been termed Folie à deux, although in rare cases, more than two persons may be involved.

Diagnostic criteria for Shared Paranoid Disorder

A. Meets the criteria for Paranoid Disorder (p. 196).

B. Delusional system develops as a result of a close relationship with another person or persons who have an established disorder with persecutory delusions.

298.30 Acute Paranoid Disorder

The essential feature is a Paranoid Disorder of less than six months' duration. It is most commonly seen in individuals who have experienced drastic changes in their environment, such as immigrants, refugees, prisoners of war, inductees into military services, or people leaving home for the first time. The onset is usually relatively sudden and the condition rarely becomes chronic.

Diagnostic criteria for Acute Paranoid Disorder

A. Meets the criteria for Paranoid Disorder (p. 196).

B. Duration of less than six months.

C. Does not meet the criteria for Shared Paranoid Disorder (p. 197).

297.90 Atypical Paranoid Disorder
This is a residual category for Paranoid Disorders not classifiable above.

Psychotic Disorders Not Elsewhere Classified

This diagnostic class is for psychotic disorders that cannot be classified as either an Organic Mental Disorder or a Schizophrenic, Paranoid, or Affective Disorder. There are three specific categories: Schizophreniform Disorder, Brief Reactive Psychosis, and Schizoaffective Disorder. Finally, there is a residual category, Atypical Psychosis, for psychotic disorders that do not meet the criteria for any specific psychotic disorder. (For a definition of "psychotic," see p. 353.)

295.40 Schizophreniform Disorder

The essential features are identical with those of Schizophrenia with the exception that the duration, including prodromal, active and residual phases, is less than six months but more than two weeks. Schizophreniform Disorder is classified outside the category of Schizophrenic Disorders because evidence suggests a greater likelihood of emotional turmoil and confusion, a tendency toward acute onset and resolution, more likely recovery to premorbid levels of functioning, and the absence of an increase in the prevalence of Schizophrenia among family members compared with the general population. The six-month criterion has been chosen because several studies indicate that this is the best single way of differentiating these two disorders to maximize the difference in their external correlates. (In the past the term "Schizophreniform" has included cases that would be classified as Schizoaffective Disorder in this manual. Therefore, some of the conclusions drawn from that body of research may not apply to Schizophreniform Disorder as defined here.)

Differential diagnosis. Since the diagnostic criteria for **Schizophrenia** and Schizophreniform Disorder differ only in duration of illness, most of the discussion of differential diagnosis in the text for Schizophrenia (p. 186) applies equally to Schizophreniform Disorder, with the exception that the clinical picture in Schizophreniform Disorder is more often characterized by emotional turmoil, fear, confusion, and particularly vivid hallucinations.

Brief Reactive Psychosis differs from Schizophreniform Disorder in that the duration of the disturbance is less than two weeks (although secondary effects may persist longer). In addition, Brief Reactive Psychosis always follows a psychosocial stressor, which frequently is not present before the onset of Schizophreniform Disorder. If what appears to be a Brief Reactive Psychosis persists beyond two weeks, a diagnosis of Schizophreniform Disorder should be considered.

Atypical Psychosis should be diagnosed if the symptom picture is consistent with that of Schizophreniform Disorder but the duration is less than two weeks and the disturbance does not follow a psychosocial stressor.

Diagnostic criteria for Schizophreniform Disorder

A. Meets all of the criteria for Schizophrenia (p. 188) except for duration.

B. The illness (including prodromal, active, and residual phases) lasts more than two weeks but less than six months.

298.80 Brief Reactive Psychosis

The essential feature is the sudden onset of a psychotic disorder of at least a few hours' but no more than two weeks' duration, with eventual return to premorbid level of functioning. The psychotic symptoms appear immediately following a recognizable psychosocial stressor that would evoke significant symptoms of distress in almost anyone. The precipitating event may be any major stress, such as the loss of a loved one or the psychological trauma of combat. Invariably there is emotional turmoil, manifested by rapid shifts from one dysphoric affect to another without the persistence of any one affect.

In order not to misdiagnose this condition when the disturbance is actually due to a more pervasive disorder, such as Schizophrenia, this diagnosis should not be made if there was a period of increasing psychopathology immediately before the psychosocial stressor.

Associated features. Frequently perplexity and a feeling of confusion are present, which the individual may acknowledge or which can be judged from the way he or she responds to questions and requests.

Behavior may be bizarre and include peculiar postures, outlandish dress, screaming, or muteness. Suicidal or aggressive behavior may also be present. Speech may include inarticulate gibberish or repetition of nonsensical phrases. Affect is often inappropriate and volatile. Transient hallucinations or delusions are common. Silly or obviously confabulated answers may be given to factual questions. Disorientation and impairment in recent memory often occur.

Age at onset. The disorder usually appears in adolescence and early adulthood.

Course. Usually the psychotic symptoms clear in a day or two. By definition this diagnosis is not applicable if the psychotic symptoms persist for more than two weeks. Transient secondary effects, such as loss of self-esteem and mild depression, may persist beyond the two weeks, but there is eventually a full return to the premorbid level of functioning.

Impairment. 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.

Complications. None.

Predisposing factors. Preexisting psychopathology may predispose to the development of this disorder. Individuals with Paranoid, Histrionic, Narcissistic, Schizotypal, or Borderline Personality Disorders are thought to be particularly vulnerable to its development. By definition situations involving major stress predispose to development of this disorder.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. Although by definition this diagnosis is not made if the psychotic symptoms persist for more than two weeks, the diagnosis can be made soon after the onset of the disturbance without waiting for the expected recovery. If the psychotic symptoms last more than two weeks, the diagnosis should be changed to either **Schizophreniform Disorder, Paranoid Disorder, Affective Disorder, or Atypical Psychosis.**

Organic Mental Disorders, particularly those involving **Delirium, Organic Delusional Syndrome,** or **Intoxication,** can be distinguished from this disorder only on the basis of historical or laboratory information that indicates a known organic factor.

Schizophreniform Disorder by definition requires a duration of more than two weeks, and frequently there is no precipitating psychosocial stressor.

Manic and major depressive episodes may follow a major psychosocial stressor. The diagnosis of a manic or major depressive episode preempts the diagnosis of Brief Reactive Psychosis, and should be made when the criteria for it are met whether or not it is associated with a psychosocial stressor.

Individuals with a **Personality Disorder** may, under stress, develop Brief Reactive Psychosis, in which case both diagnoses should be made.

An episode of **Factitious Disorder with Psychological Symptoms** may have apparently psychotic symptoms and may also be precipitated by a psychosocial stressor, but in such cases there is evidence that the symptoms are under voluntary control.

When **Malingering** presents with apparently psychotic symptoms, there is usually evidence that the illness was feigned for an understandable goal.

Diagnostic criteria for Brief Reactive Psychosis

A. Psychotic symptoms appear immediately following a recognizable psychosocial stressor that would evoke significant symptoms of distress in almost anyone.

B. The clinical picture involves emotional turmoil and at least one of the following psychotic symptoms:

(1) incoherence or loosening of associations
(2) delusions
(3) hallucinations
(4) behavior that is grossly disorganized or catatonic

C. The psychotic symptoms last more than a few hours but less than two weeks, and there is an eventual return to the premorbid level of functioning. (Note: The diagnosis can be made soon after the onset of the psychotic symptoms without waiting for the expected recovery. If the psychotic symptoms last more than two weeks, the diagnosis should be changed.)

D. No period of increasing psychopathology immediately preceded the psychosocial stressor.

E. The disturbance is not due to any other mental disorder, such as an Organic Mental Disorder, manic episode, or Factitious Disorder with Psychological Symptoms.

295.70 Schizoaffective Disorder

The term Schizoaffective Disorder has been used in many different ways since it was first introduced, and at the present time there is no consensus on how this category should be defined. Some of the cases that in the past were diagnosed as Schizoaffective Disorder would in this manual be diagnosed as Schizophreniform Disorder, Major Depression or Bipolar Disorder with Mood-congruent or Mood-incongruent Psychotic Features, or Schizophrenia with a superimposed Atypical Affective Disorder. Future research is needed to determine whether there is a need for this category, and if so, how it should be defined and what its relationship is to Schizophrenia and Affective Disorder.

The category is retained in this manual without diagnostic criteria for those instances in which the clinician is unable to make a differential diagnosis with any degree of certainty between Affective Disorder and either Schizophreniform Disorder or Schizophrenia. Before using the Schizoaffective Disorder category, the clinician should consider all of the diagnoses noted in the first paragraph above, particularly Major Affective Disorders with Psychotic Features.

Examples of cases that may appropriately be diagnosed as Schizoaffective Disorder include:

An episode of affective illness in which preoccupation with a mood-incongruent delusion or hallucination dominates the clinical picture when affective symptoms are no longer present.

An episode of illness in which currently there is a full affective syndrome with prominent mood-incongruent psychotic features but in which inadequate information about the presence of previous non-affective psychotic features makes it difficult to differentiate between Schizophrenia or Schizophreniform Disorder (with a superimposed Atypical Affective Disorder) and Affective Disorder.

298.90 Atypical Psychosis

This is a residual category for cases in which there are psychotic symptoms (delusions, hallucinations, incoherence, loosening of associations, markedly illog-

ical thinking, or behavior that is grossly disorganized or catatonic) that do not meet the criteria for any specific mental disorder.

Common examples of this category include:

(1) Psychoses with unusual features, e.g., monosymptomatic delusion of bodily change without accompanying impairment in functioning; persistent auditory hallucinations as the only disturbance; transient psychotic episodes associated with the menstrual cycle.

(2) "Postpartum psychoses" that do not meet the criteria for an Organic Mental Disorder, Schizophreniform Disorder, Paranoid Disorder, or Affective Disorder.

(3) Psychoses that would be classified elsewhere except that the duration is less than two weeks, e.g., the symptomatology of a Schizophreniform Disorder, but lasting only three days and there is no precipitating psychosocial stressor.

(4) Psychoses about which there is inadequate information to make a more specific diagnosis. (This is preferable to Diagnosis Deferred, and can be changed if more information becomes available.)

(5) Psychoses with confusing clinical features that make a more specific diagnosis impossible.

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Affective Disorders*

The essential feature of this group of disorders is a disturbance of mood, accompanied by a full or partial manic or depressive syndrome, that is not due to any other physical or mental disorder. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The manic and depressive syndromes each consist of characteristic symptoms that tend to occur together.

In other classifications these disorders are grouped in various categories, including Affective, Personality, and Neurotic Disorders.

Subclassification of Affective Disorders. The classification of Affective Disorders in DSM-III differs from many other classifications based on such dichotomous distinctions as neurotic vs. psychotic or endogenous vs. reactive.

In this manual the class Affective Disorders is divided into Major Affective Disorders, in which there is a full affective syndrome; Other Specific Affective Disorders, in which there is only a partial affective syndrome of at least two years' duration; and finally, Atypical Affective Disorders, a category for those affective disorders that cannot be classified in either of the two specific subclasses.

Major Affective Disorders include Bipolar Disorder and Major Depression, which are distinguished by whether or not there has ever been a manic episode. A category of Manic Disorder is not included in this classification; instead, when there has been one or more manic episodes, with or without a history of a major depressive episode, the category Bipolar Disorder is used. Bipolar Disorder is subclassified at the fourth digit as Mixed, Manic, or Depressed; Major Depression is subclassified at the fourth digit as Single Episode or Recurrent. The current episode is further subclassified at the fifth digit to reflect certain characteristics such as the presence of psychotic features and, in the case of a major depressive episode, the presence of Melancholia.†

Other Specific Affective Disorders include Cyclothymic Disorder and Dysthymic Disorder. In Cyclothymic Disorder there are symptoms characteristic of both the depressive and the manic syndromes, but they are not of sufficient severity and duration to meet the criteria for major depressive or manic episodes. In Dysthymic Disorder the symptoms are not of sufficient severity and duration

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* The proper descriptive term for this group of disorders should be "Mood Disorders"; however, common usage and historical continuity favor retention of the term "Affective Disorders."

† A term from the past, in this manual used to indicate a typically severe form of depression that is particularly responsive to somatic therapy. The clinical features that characterize this syndrome have been referred to as "endogenous." Since the term "endogenous" implies, to many, the absence of precipitating stress, a characteristic not always associated with this syndrome, the term "endogenous" is not used in DSM-III.

to meet the criteria for a major depressive episode, and there have been no hypomanic periods. A theoretically possible third disorder in this group is Chronic Hypomanic Disorder, which would require hypomanic features of at least two years' duration, but not depressive periods; the existence of such a syndrome has not been well enough established to warrant inclusion as a distinct disorder. These chronic disorders may have a superimposed episode of Major Affective Disorder, in which case both diagnoses should be recorded.

MAJOR AFFECTIVE DISORDERS*

The essential feature is an illness involving either a manic episode (see below) or a major depressive episode (p. 210). These major affective episodes are not diagnosed if the affective disturbance is due to an Organic Mental Disorder or if it is superimposed on Schizophrenia.

Manic Episode

The essential feature is a distinct period when the predominant mood is either elevated, expansive, or irritable and when there are associated symptoms of the manic syndrome. These symptoms include hyperactivity, pressure of speech, flight of ideas, inflated self-esteem, decreased need for sleep, distractibility, and excessive involvement in activities that have a high potential for painful consequences, which is not recognized.

The elevated mood may be described as euphoric, unusually good, cheerful, or high; often has an infectious quality for the uninvolved observer; but is recognized as excessive by those who know the individual well. The expansive quality of the mood disturbance is characterized by unceasing and unselective enthusiasm for interacting with people and seeking involvement with other aspects of the environment. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, which may be most apparent when the individual is thwarted.

The hyperactivity often involves excessive planning of and participation in multiple activities (e.g., sexual, occupational, political, religious). Almost invariably there is increased sociability, which includes efforts to renew old acquaintanceships and calling friends at all hours of the night. The intrusive, domineering, and demanding nature of these interactions is not recognized by the individual. Frequently, expansiveness, unwarranted optimism, grandiosity, and lack of judgment lead to such activities as buying sprees, reckless driving, foolish business investments, and sexual behavior unusual for the individual. Often the activities have a disorganized, flamboyant, or bizarre quality, for example, dressing in colorful or strange garments, wearing excessive, poorly applied make-up, or distributing candy, money, or advice to passing strangers.

Manic speech is typically loud, rapid, and difficult to interrupt. Often it is

* The organization of the text for the Major Affective Disorders departs from the usual method of presentation in order to avoid redundancy. The essential features, associated features, differential diagnosis and diagnostic criteria of manic and major depressive episodes are described first. Age at onset, course and other features of both manic and major depressive episodes are discussed next. Finally, the diagnostic criteria for the specific Major Affective Disorders are listed.

full of jokes, puns, plays on words, and amusing irrelevancies. It may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (clanging). If the mood is more irritable than expansive, there may be complaints, hostile comments, and angry tirades.

Frequently there is flight of ideas, i.e., a nearly continuous flow of accelerated speech with abrupt changes from topic to topic, usually based on understandable associations, distracting stimuli, or plays on words. When flight of ideas is severe, the speech may be disorganized and incoherent. However, loosening of associations and incoherence may occur even when there is no flight of ideas, particularly if the individual is on medication.

Distractibility is usually present and manifests itself as rapid changes in speech or activity as a result of responding to various irrelevant external stimuli, such as background noise or signs or pictures on the wall.

Characteristically, there is inflated self-esteem, ranging from uncritical self-confidence to marked grandiosity, which may be delusional. For instance, advice may be given on matters about which the individual has no special knowledge, such as how to run a mental hospital or the United Nations. Despite a lack of any particular talent, a novel may be started, music composed, or publicity sought for some impractical invention. Grandiose delusions involving a special relationship to God or some well-known figure from the political, religious, or entertainment world are common.

Almost invariably there is a decreased need for sleep; the individual awakens several hours before the usual time, full of energy. When the sleep disturbance is severe, the individual may go for days without any sleep at all and yet not feel tired.

The term "hypomania" is used to describe a clinical syndrome that is similar to, but not as severe as, that described by the term "mania" or "manic episode."

Associated features. A common associated feature is lability of mood, with rapid shifts to anger or depression. The depression, expressed by tearfulness, suicidal threats, or other depressive symptoms, may last moments, hours, or, more rarely, days. Occasionally the depressive and manic symptoms intermingle, occurring at the same time; or they may alternate rapidly within a few days. Less often, in Bipolar Disorder, Mixed, the depressive symptoms are more prominent and last at least a full day, and there is the full symptom picture of manic and major depressive episodes.

When delusions or hallucinations are present, their content is usually clearly consistent with the predominant mood (mood-congruent). God's voice may be heard explaining that the individual has a special mission. Persecutory delusions may be based on the idea that the individual is being persecuted because of some special relationship or attribute. Less commonly, the content of the hallucinations or delusions has no apparent relationship to the predominant mood (mood-incongruent). The usefulness of the distinction between mood-congruent and mood-incongruent psychotic features is controversial.

Differential diagnosis of manic episode. Organic Affective Syndromes with mania may be due to such substances as amphetamines or steroids, or to some other known organic factor, such as multiple sclerosis. The diagnosis of a manic episode should be made only if a known organic etiology can be excluded. For further discussion, see p. 117.

In **Schizophrenia, Paranoid Type**, there may be irritability and anger that are difficult to distinguish from similar features in a manic episode. In such instances it may be necessary to rely on features that, on a statistical basis, are associated differentially with the two conditions. For example, the diagnosis of a manic episode is more likely if there is a family history of Affective Disorder, good premorbid adjustment, and a previous episode of an Affective Disorder from which there was complete recovery.

The diagnosis **Schizoaffective Disorder** may be made whenever the clinician is unable to make a differential diagnosis between manic episode and Schizophrenia. Although no criteria for Schizoaffective Disorder are provided in this manual, several examples of clinical situations in which this diagnosis might be appropriate are given on p. 202.

In **Cyclothymic Disorder** there are hypomanic periods, but the full manic syndrome is not present. However, in some instances a manic episode may be superimposed on Cyclothymic Disorder. In such cases both Bipolar Disorder and Cyclothymic Disorder should be diagnosed, since it is likely that when the individual recovers from the manic episode, the Cyclothymic Disorder will persist.

Diagnostic criteria for a manic episode

A. One or more distinct periods with a predominantly elevated, expansive, or irritable mood. The elevated or irritable mood must be a prominent part of the illness and relatively persistent, although it may alternate or intermingle with depressive mood.

B. Duration of at least one week (or any duration if hospitalization is necessary), during which, for most of the time, at least three of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) increase in activity (either socially, at work, or sexually) or physical restlessness
(2) more talkative than usual or pressure to keep talking
(3) flight of ideas or subjective experience that thoughts are racing
(4) inflated self-esteem (grandiosity, which may be delusional)
(5) decreased need for sleep
(6) distractibility, i.e., attention is too easily drawn to unimportant or irrelevant external stimuli
(7) excessive involvement in activities that have a high potential for painful consequences which is not recognized, e.g., buying sprees, sexual indiscretions, foolish business investments, reckless driving

C. Neither of the following dominates the clinical picture when an affective syndrome is absent (i.e., symptoms in criteria A and B above):

(1) preoccupation with a mood-incongruent delusion or hallucination (see definition below)
(2) bizarre behavior

D. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.

E. Not due to any Organic Mental Disorder, such as Substance Intoxication.

(**Note:** A hypomanic episode is a pathological disturbance similar to, but not as severe as, a manic episode.)

Fifth-digit code numbers and criteria for subclassification of manic episode

6– In Remission. This fifth-digit category should be used when in the past the individual met the full criteria for a manic episode but now is essentially free of manic symptoms or has some signs of the disorder but does not meet the full criteria. The differentiation of this diagnosis from no mental disorder requires consideration of the period of time since the last episode, the number of previous episodes, and the need for continued evaluation or prophylactic treatment.

4– With Psychotic Features. This fifth-digit category should be used when there apparently is gross impairment in reality testing, as when there are delusions or hallucinations or grossly bizarre behavior. When possible, specify whether the psychotic features are mood-incongruent. (The non-ICD-9-CM fifth-digit 7 may be used instead to indicate that the psychotic features are mood-incongruent; otherwise, mood-congruence may be assumed.)

Mood-congruent Psychotic Features: Delusions or hallucinations whose content is entirely consistent with the themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person; flight of ideas without apparent awareness by the individual that the speech is not understandable.

Mood-incongruent Psychotic Features: Either (a) or (b):
(a) Delusions or hallucinations whose content does not involve themes of either inflated worth, power, knowledge, identity, or special relationship to a deity or famous person. Included are such symptoms as persecutory delusions, thought insertion, and delusions of being controlled, whose content has no apparent relationship to any of the themes noted above.

(b) Any of the following catatonic symptoms: stupor, mutism, negativism, posturing.

2– Without Psychotic Features. Meets the criteria for manic episode, but no psychotic features are present.

0– Unspecified.

Major Depressive Episode

The essential feature is either a dysphoric mood, usually depression, or loss of interest or pleasure in all or almost all usual activities and pastimes. This disturbance is prominent, relatively persistent, and associated with other symptoms of the depressive syndrome. These symptoms include appetite disturbance, change in weight, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or guilt, difficulty concentrating or thinking, and thoughts of death or suicide or suicidal attempts.

An individual with a depressive syndrome will usually describe his or her mood as depressed, sad, hopeless, discouraged, down in the dumps, or in terms of some other colloquial variant. Sometimes, however, the mood disturbance may not be expressed as a synonym for depressive mood but rather as a complaint of "not caring anymore," or as a painful inability to experience pleasure. In a child with a depressive syndrome there may not be complaints of any dysphoric mood, but its existence may be inferred from a persistently sad facial expression.

Loss of interest or pleasure is probably always present in a major depressive episode to some degree, but the individual may not complain of this or even be aware of the loss, although family members may notice it. Withdrawal from friends and family and neglect of avocations that were previously a source of pleasure are common.

Appetite is frequently disturbed, usually with loss of appetite, but occasionally with increased appetite. When loss of appetite is severe, there may be significant weight loss or, in the case of children, failure to make expected weight gains. When appetite is markedly increased there may be significant weight gain.

Sleep is commonly disturbed, more frequently with insomnia present, but sometimes with hypersomnia. The insomnia may involve difficulty falling asleep (initial insomnia), waking up during sleep and then returning to sleep only with difficulty (middle insomnia), or early morning awakening (terminal insomnia).

Psychomotor agitation takes the form of inability to sit still, pacing, handwringing, pulling or rubbing of hair, skin, clothing, or other objects, outbursts of complaining or shouting, or pressure of speech. Psychomotor retardation may take the form of slowed speech, increased pauses before answering, low or monotonous speech, slowed body movements, a markedly decreased amount of speech (poverty of speech), or muteness. (In children there may be hypoactivity rather than psychomotor retardation.) A decrease in energy level is almost

invariably present, and is experienced as sustained fatigue even in the absence of physical exertion. The smallest task may seem difficult or impossible to accomplish.

The sense of worthlessness varies from feelings of inadequacy to completely unrealistic negative evaluations of one's worth. The individual may reproach himself or herself for minor failings that are exaggerated and search the environment for cues confirming the negative self-evaluation. Guilt may be expressed as an excessive reaction to either current or past failings or as exaggerated responsibility for some untoward or tragic event. The sense of worthlessness or guilt may be of delusional proportions.

Difficulty in concentrating, slowed thinking, and indecisiveness are frequent. The individual may complain of memory difficulty and appear easily distracted.

Thoughts of death or suicide are common. There may be fear of dying, the belief that the individual or others would be better off dead, wishes to die, or suicidal plans or attempts.

Associated features. Common associated features include depressed appearance, tearfulness, feelings of anxiety, irritability, fear, brooding, excessive concern with physical health, panic attacks, and phobias.

When delusions or hallucinations are present, their content is usually clearly consistent with the predominant mood (mood-congruent). A common delusion is that one is being persecuted because of sinfulness or some inadequacy. There may be nihilistic delusions of world or personal destruction, somatic delusions of cancer or other serious illness, or delusions of poverty. Hallucinations, when present, are usually transient and not elaborate, and may involve voices that berate the individual for his or her shortcomings or sins.

Less commonly the content of the hallucinations or delusions has no apparent relationship to the mood disturbance (mood-incongruent). This is particularly the case with persecutory delusions, in which the individual may be at a loss to explain why he or she should be the object of persecution. The usefulness of the distinction between mood-congruent and mood-incongruent psychotic features is controversial.

Age-specific associated features. Although the essential features of a major depressive episode are similar in infants, children, adolescents, and adults, there are differences in the associated features.

In prepubertal children separation anxiety may develop and cause the child to cling, to refuse to go to school, and to fear that he or she or the parents will die. A previous history of separation anxiety may result in more intense anxiety symptoms with the onset of a major depressive episode.

In adolescent boys negativistic or frankly antisocial behavior may appear. Feelings of wanting to leave home or of not being understood and approved of, restlessness, grouchiness, and aggression are common. Sulkiness, a reluctance to cooperate in family ventures, and withdrawal from social activities, with retreat to one's room, are frequent. School difficulties are likely. There may be

inattention to personal appearance and increased emotionality, with particular sensitivity to rejection in love relationships. Substance Abuse may develop.

In elderly adults there may be symptoms suggesting Dementia, such as disorientation, memory loss, and distractibility. Loss of interest or pleasure in the individual's usual activities may appear as apathy; difficulty in concentration as inattentiveness. These symptoms make the differential diagnosis of "pseudodementia" (due to depression) from true Dementia (an Organic Mental Disorder) particularly difficult (p. 111).

Differential diagnosis of major depressive episode. An **Organic Affective Syndrome with depression** may be due to substances such as reserpine, to infectious diseases such as influenza, or to hypothyroidism. Only by excluding organic etiology can one make the diagnosis of a major depressive episode. For further discussion, see p. 117.

Primary Degenerative Dementia or **Multi-infarct Dementia**, because of the presence of disorientation, apathy, and complaints of difficulty concentrating or of memory loss, may be difficult to distinguish from a major depressive episode occurring in the elderly. If the features suggesting a major depressive episode are at least as prominent as those suggesting Dementia, it is best to diagnose a major depressive episode and assume that the features suggesting Dementia represent a pseudo-dementia that is a manifestation of the major depressive episode. In such cases the successful treatment of the major depressive episode often results in the disappearance of the symptoms suggesting Dementia. If the features suggesting Dementia are more prominent than the depressive features, the diagnosis should be the appropriate form of Dementia, but the presence of depressive features should be noted.

If a **psychological reaction to the functional impairment associated with a physical illness** that does not involve the central nervous system causes a depression that meets the full criteria for a major depressive episode, the Major Depression should be recorded on Axis I, the physical disorder on Axis III, and the severity of the psychosocial stressor on Axis IV. Examples would include the psychological reaction to the amputation of a leg or to the development of a life-threatening or incapacitating illness.

In **Schizophrenia** there is usually considerable depressive symptomatology. If an episode of depression follows an episode of Schizophrenia and is superimposed upon the residual phase of Schizophrenia, the additional diagnosis of either Atypical Depression or Adjustment Disorder with Depressed Mood may be made, but not Major Depression. An individual with a major depressive episode may have psychotic symptoms; however, the diagnosis of Schizophrenia is made in the presence of a full depressive syndrome only if the affective symptoms follow the psychotic symptoms or are brief relative to the duration of the psychotic symptoms. An individual with Schizophrenia, Catatonic Type, may appear to be withdrawn and depressed, and it may be difficult to distinguish this condition from Major Depression with psychomotor retardation. In such instances it may be necessary to rely on features that on a statistical basis are associated differentially with the two disorders. For example, the diagnosis of a major depressive episode is more likely if there is a family history

of Affective Disorder, good premorbid adjustment, and a previous episode of affective disturbance from which there was complete recovery.

The diagnosis of **Schizoaffective Disorder** can be made whenever the clinician is unable to make a differential diagnosis between a major depressive episode and Schizophrenia. Although no criteria for Schizoaffective Disorder are provided in this manual, several examples of clinical situations in which this diagnosis might be appropriate are given on p. 202.

In **Dysthymic** and **Cyclothymic Disorders** there are features of the depressive syndrome, but they are not of sufficient severity and duration to meet the criteria for a major depressive episode. However, in some instances, a major depressive episode is superimposed on one of these disorders. In such cases both diagnoses should be recorded, since it is likely that after recovering from the major depressive episode, either a Dysthymic or a Cyclothymic Disorder will persist.

Chronic mental disorders, such as **Obsessive Compulsive Disorder** or **Alcohol Dependence**, when associated with depressive symptoms, may suggest a Major Depression. The additional diagnosis of Major Depression should be made only if the full depressive syndrome is present and persistent. In such instances both the chronic mental disorder and the superimposed Major Depression should be recorded.

In **Separation Anxiety Disorder**, depressive symptoms are common, but if the full depressive syndrome is not present, only Separation Anxiety Disorder should be diagnosed. On the other hand, children with Separation Anxiety Disorder may develop a superimposed major depressive episode, in which case both diagnoses should be made.

Uncomplicated Bereavement is distinguished from a major depressive episode and is not considered a mental disorder even when associated with the full depressive syndrome (see p. 333). However, if bereavement is unduly severe or prolonged, the diagnosis may be changed to Major Depression.

Diagnostic criteria for major depressive episode

A. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and pastimes. The dysphoric mood is characterized by symptoms such as the following: depressed, sad, blue, hopeless, low, down in the dumps, irritable. The mood disturbance must be prominent and relatively persistent, but not necessarily the most dominant symptom, and does not include momentary shifts from one dysphoric mood to another dysphoric mood, e.g., anxiety to depression to anger, such as are seen in states of acute psychotic turmoil. (For children under six, dysphoric mood may have to be inferred from a persistently sad facial expression.)

B. At least four of the following symptoms have each been present nearly every day for a period of at least two weeks (in children under six, at least three of the first four).

(1) poor appetite or significant weight loss (when not dieting) or increased appetite or significant weight gain (in children under six, consider failure to make expected weight gains)
(2) insomnia or hypersomnia
(3) psychomotor agitation or retardation (but not merely subjective feelings of restlessness or being slowed down) (in children under six, hypoactivity)
(4) loss of interest or pleasure in usual activities, or decrease in sexual drive not limited to a period when delusional or hallucinating (in children under six, signs of apathy)
(5) loss of energy; fatigue
(6) feelings of worthlessness, self-reproach, or excessive or inappropriate guilt (either may be delusional)
(7) complaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness not associated with marked loosening of associations or incoherence
(8) recurrent thoughts of death, suicidal ideation, wishes to be dead, or suicide attempt

C. Neither of the following dominate the clinical picture when an affective syndrome is absent (i.e., symptoms in criteria A and B above):

(1) preoccupation with a mood-incongruent delusion or hallucination (see definition below)
(2) bizarre behavior

D. Not superimposed on either Schizophrenia, Schizophreniform Disorder, or a Paranoid Disorder.

E. Not due to any Organic Mental Disorder or Uncomplicated Bereavement.

Fifth-digit code numbers and criteria for subclassification of major depressive episode
(When psychotic features and Melancholia are present the coding system requires that the clinician record the single most clinically significant characteristic.)

6– In Remission. This fifth-digit category should be used when in the past the individual met the full criteria for a major depressive episode but now is essentially free of depressive symptoms or has some signs of the disorder but does not meet the full criteria.

4– With Psychotic Features. This fifth-digit category should be used when there apparently is gross impairment in reality testing, as when there are delusions or hallucinations, or depressive stupor (the individual

is mute and unresponsive). When possible, specify whether the psychotic features are mood-congruent or mood-incongruent. (The non-ICD-9-CM fifth-digit 7 may be used instead to indicate that the psychotic features are mood-incongruent; otherwise, mood-congruence may be assumed.)

Mood-congruent Psychotic Features. Delusions or hallucinations whose content is entirely consistent with the themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment; depressive stupor (the individual is mute and unresponsive).

Mood-incongruent Psychotic Features. Delusions or hallucinations whose content does not involve themes of either personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included here are such symptoms as persecutory delusions, thought insertion, thought broadcasting, and delusions of control, whose content has no apparent relationship to any of the themes noted above.

3– **With Melancholia.** Loss of pleasure in all or almost all activities, lack of reactivity to usually pleasurable stimuli (doesn't feel much better, even temporarily, when something good happens), and at least three of the following:

(a) distinct quality of depressed mood, i.e., the depressed mood is perceived as distinctly different from the kind of feeling experienced following the death of a loved one

(*b*) the depression is regularly worse in the morning

(*c*) early morning awakening (at least two hours before usual time of awakening)

(*d*) marked psychomotor retardation or agitation

(e) significant anorexia or weight loss

(*f*) excessive or inappropriate guilt

2– **Without Melancholia**

0– **Unspecified**

OTHER FEATURES OF BOTH MANIC AND MAJOR DEPRESSIVE EPISODES

Age at onset. The first manic episode of Bipolar Disorder typically occurs before age 30. Major Depression may begin at any age, including infancy, and the age at onset is fairly evenly distributed throughout adult life.

Course. Manic episodes typically begin suddenly, with a rapid escalation of symptoms over a few days. The episodes usually last from a few days to months and are briefer and end more abruptly than major depressive episodes.

Most individuals who have a disorder characterized by one or more manic episodes (Bipolar Disorder) will eventually have a major depressive episode.

The onset of a major depressive episode is variable, the symptoms usually developing over a period of days to weeks; but in some cases it may be sudden (e.g., when associated with a severe psychosocial stress). In some instances prodromal symptoms—e.g., generalized anxiety, panic attacks, phobias, or mild depressive symptoms—may occur over a period of several months. It is estimated that over 50% of individuals with a Major Depression, Single Episode, will eventually have another major depressive episode, thus meeting the criteria for Major Depression, Recurrent. Individuals with Major Depression, Recurrent, are at greater risk of developing Bipolar Disorder than are those with a single episode of Major Depression.

In Bipolar Disorder the initial episode is often manic. Both the manic and the major depressive episodes are more frequent and shorter than the major depressive episodes in Major Depression. Frequently a manic or major depressive episode is immediately followed by a short episode of the other kind. In rare cases, over long periods of time there is an alternation of the two kinds of episodes without an intervening period of normal mood (cycling).

The course of Major Affective Disorders is variable. Some individuals have episodes separated by many years of normal functioning; others have clusters of episodes; and still others have an increased frequency of episodes as they grow older. Usually functioning returns to the premorbid level between episodes. However, in 20% to 35% of cases there is a chronic course with considerable residual symptomatic and social impairment. This is more likely when there are frequent recurrent episodes.

Impairment. In manic episodes there are usually considerable impairment in both social and occupational functioning and a need for protection from the consequences of poor judgment or hyperactivity.

In major depressive episodes the degree of impairment varies, but there is always some interference in social and occupational functioning. If impairment is severe, the individual may be totally unable to function socially or occupationally, or even to feed or clothe himself or herself or maintain minimal personal hygiene.

Complications. The most common complications of a manic episode are Substance Abuse and the consequences of actions resulting from impaired judgment, such as financial losses and illegal activities.

The most serious complication of a major depressive episode is suicide.

Predisposing factors. Chronic physical illness, Alcohol Dependence, Cyclothymic and Dysthymic Disorders apparently predispose to the development of a Major Affective Disorder.

Frequently an episode of Major Affective Disorder follows a psychosocial stressor. If an individual has recurrent episodes, however, subsequent episodes may occur apparently without precipitating factors.

Prevalence and sex ratio. Studies in Europe and in the United States indicate that in the adult population, approximately 18% to 23% of the females and 8% to 11% of the males have at some time had a major depressive episode. It is estimated that 6% of the females and 3% of the males have had a major depressive episode sufficiently severe to require hospitalization.

It is estimated that from 0.4% to 1.2% of the adult population have had Bipolar Disorder. In contrast to Major Depression, Bipolar Disorder is apparently equally common in women and in men.

Familial pattern. Major Affective Disorders are more common among family members than in the general population. This is particularly true for family members of individuals with Bipolar Disorder.

DIAGNOSTIC CRITERIA FOR MAJOR AFFECTIVE DISORDERS

Bipolar Disorder

296.6x Bipolar Disorder, Mixed

Diagnostic criteria for Bipolar Disorder, Mixed

Use fifth-digit coding for manic episode.

A. Current (or most recent) episode involves the full symptomatic picture of both manic and major depressive episodes (p. 208 and p. 213), intermixed or rapidly alternating every few days.

B. Depressive symptoms are prominent and last at least a full day.

296.4x Bipolar Disorder, Manic

Diagnostic criteria for Bipolar Disorder, Manic

Currently (or most recently) in a manic episode (p. 208). (If there has been a previous manic episode, the current episode need not meet the full criteria for a manic episode.)

296.5x Bipolar Disorder, Depressed

Diagnostic criteria for Bipolar Disorder, Depressed

A. Has had one or more manic episodes (p. 208).

B. Currently (or most recently) in a major depressive episode (p. 213). (If there has been a previous major depressive episode, the current episode of depression need not meet the full criteria for a major depressive episode.)

MAJOR DEPRESSION

296.2x Major Depression, Single Episode

296.3x Major Depression, Recurrent

Diagnostic criteria for Major Depression
A. One or more major depressive episodes (p. 213).

B. Has never had a manic episode (p. 208).

OTHER SPECIFIC AFFECTIVE DISORDERS

The essential feature is a long-standing illness of at least two years' duration, with either sustained or intermittent disturbance in mood, and associated symptoms. A full affective syndrome is not present, and there are no psychotic features. These disorders usually begin in early adult life, without a clear onset. This category contains two disorders: Cyclothymic Disorder and Dysthymic Disorder. Other terms for these disorders are Cyclothymic and Depressive Personality Disorders.

301.13 Cyclothymic Disorder

The essential feature is a chronic mood disturbance of at least two years' duration, involving numerous periods of depression and hypomania, but not of sufficient severity and duration to meet the criteria for a major depressive or a manic episode (full affective syndrome).

The depressive periods and hypomanic periods may be separated by periods of normal mood lasting as long as several months at a time. In other cases the two types of periods are intermixed or alternate.

During the affective periods there are signs of depression (depressed mood or loss of interest or pleasure in all, or almost all, usual activities and pastimes) and hypomania. In addition, during the affective periods there are paired sets of symptoms (see criterion C below). The following pairs of symptoms are particularly common: feelings of inadequacy (during depressed periods) and inflated self-esteem (during hypomanic periods); social withdrawal and uninhibited people-seeking; sleeping too much and decreased need for sleep; diminished productivity at work and increased productivity, often associated with unusual and self-imposed working hours; decreased attention or concentration and sharpened and unusually creative thinking.

Associated features. Associated features are similar to those of manic episode (p. 207) and major depressive episode (p. 211) except that by definition there are no psychotic features such as delusions, hallucinations, incoherence, or loosening of associations. Substance Abuse is particularly common as a result of

self-treatment with sedatives and alcohol during the depressed periods and the self-indulgent use of stimulants and psychedelics during the hypomanic periods.

Age at onset. Usually early adult life.

Course. The disorder usually begins without clear onset and has a chronic course.

Impairment. Impairment in social and occupational functioning is usually moderate or severe.

Complications. See manic and major depressive episodes (p. 216). Frequently manic and major depressive episodes are complications of this disorder. For this reason some investigators believe that Cyclothymic Disorder is a mild form of Bipolar Disorder.

Predisposing factors. No information.

Prevalence. This disorder was previously assumed to be rare. Recent evidence suggests that among outpatients the disorder may be relatively common, the depressive and hypomanic periods being manifested by loss of interest or pleasure and an expansive or irritable mood rather than by acknowledged depressed and elevated moods.

Sex ratio. The disorder is apparently more common in females.

Familial pattern. Major Depression and Bipolar Disorder are more common among family members of individuals with Cyclothymic Disorder than in the general population.

Differential diagnosis. See manic (p. 208) and major depressive episodes (p. 213). When a **major depressive** or **manic episode** is superimposed on Cyclothymic Disorder, both diagnoses should be made because it is likely that the individual will continue to have Cyclothymic Disorder after recovery from the Major Affective Disorder.

Diagnostic criteria for Cyclothymic Disorder

A. During the past two years, numerous periods during which some symptoms characteristic of both the depressive and the manic syndromes were present, but were not of sufficient severity and duration to meet the criteria for a major depressive or manic episode.

B. The depressive periods and hypomanic periods may be separated by periods of normal mood lasting as long as months at a time, they may be intermixed, or they may alternate.

C. During **depressive** periods there is depressed mood or loss of interest or pleasure in all or almost all, usual activities and pastimes, and at least three of the following:	During **hypomanic** periods there is an elevated, expansive, or irritable mood and at least three of the following:
(1) insomnia or hypersomnia	(1) decreased need for sleep
(2) low energy or chronic fatigue	(2) more energy than usual
(3) feelings of inadequacy	(3) inflated self-esteem
(4) decreased effectiveness or productivity at school, work, or home	(4) increased productivity, often associated with unusual and self-imposed working hours
(5) decreased attention, concentration, or ability to think clearly	(5) sharpened and unusually creative thinking
(6) social withdrawal	(6) uninhibited people-seeking (extreme gregariousness)
(7) loss of interest in or enjoyment of sex	(7) hypersexuality without recognition of possibility of painful consequences
(8) restriction of involvement in pleasurable activities; guilt over past activities	(8) excessive involvement in pleasurable activities with lack of concern for the high potential for painful consequences, e.g., buying sprees, foolish business investments, reckless driving
(9) feeling slowed down	(9) physical restlessness
(10) less talkative than usual	(10) more talkative than usual
(11) pessimistic attitude toward the future, or brooding about past events	(11) overoptimism or exaggeration of past achievements
(12) tearfulness or crying	(12) inappropriate laughing, joking, punning

D. Absence of psychotic features such as delusions, hallucinations, incoherence, or loosening of associations.

E. Not due to any other mental disorder, such as partial remission of Bipolar Disorder. However, Cyclothymic Disorder may precede Bipolar Disorder.

300.40 Dysthymic Disorder (or Depressive Neurosis)

The essential feature is a chronic disturbance of mood involving either depressed mood or loss of interest or pleasure in all, or almost all, usual activities and

pastimes, and associated symptoms, but not of sufficient severity and duration to meet the criteria for a major depressive episode (full affective syndrome).

For adults, two years' duration is required; for children and adolescents, one year is sufficient.

The depressed mood may be characterized by the individual as feeling sad, blue, down in the dumps, or low. The depressed mood or loss of interest or pleasure may be either relatively persistent or intermittent and separated by periods of normal mood, interest, and pleasure. These normal periods may last a few days to a few weeks. The diagnosis should not be made if an apparently chronic course has been interrupted by a period of normal mood lasting more than a few months.

During the depressive periods there are some of the milder features of the depressive syndrome described as part of a major depressive episode on p. 210 (see criterion D below).

Associated features. Associated features (and age-specific associated features) are similar to those of major depressive episode (p. 211), except that by definition there are no delusions or hallucinations.

Often an associated personality disturbance warrants an additional diagnosis of a Personality Disorder on Axis II.

Age at onset. This disorder usually begins early in adult life, and for this reason was often referred to as Depressive Personality. Although it may begin in childhood or adolescence, in other cases it may begin at a period later in adulthood, in some instances following a Major Depression.

Course. The disorder usually begins without clear onset and has a chronic course.

Impairment and complications. The impairment in social and occupational functioning is usually mild or moderate because of the chronicity rather than the severity of the depressive syndrome. Therefore, hospitalization is rarely required unless there is a suicide attempt or a superimposed Major Affective Disorder. The complications are similar to those of Major Depression, although, because of the chronicity of this disorder, there may be a greater likelihood of developing Substance Abuse.

In children and adolescents social interaction with peers and adults is frequently affected. Children with depression often react negatively or shyly to praise and frequently respond to positive relationships with negative behaviors (sometimes testing, sometimes as manifestations of unexpressed resentment and anger). School performance and progress may be deleteriously affected.

Predisposing factors. Predisposing factors include chronic physical disorder, chronic psychosocial stressors, and another mental disorder, such as a Personality Disorder or an Affective Disorder that does not completely remit and merges imperceptibly into this condition.

In children and adolescents predisposing factors are the presence of Attention Deficit Disorder, Conduct Disorder, Mental Retardation, a severe Specific Developmental Disorder or an inadequate, disorganized, rejecting and chaotic environment.

Prevalence. This disorder is apparently common.

Sex ratio. Among adults the disorder is apparently more common in females. In children it seems to occur equally frequently in both sexes.

Familial pattern. No information.

Differential diagnosis. For a discussion of the differential diagnosis with **major depressive episode,** see p. 213.

When a Major Depression is in partial remission for a period of two years, Dysthymic Disorder should be considered as an alternative diagnosis to Major Depression in Remission. When a Major Depression is superimposed on Dysthymic Disorder, both diagnoses should be recorded since it is likely that the individual will continue to have the Dysthymic Disorder when he or she has recovered from the Major Depression.

Often the affective features of this disorder are viewed as secondary to an underlying **Personality Disorder.** When an individual meets the criteria for both this disorder and a Personality Disorder, both diagnoses should be made regardless of the causal relationship between the two. This disorder is particularly common in individuals with Borderline, Histrionic and Dependent Personality Disorders.

Normal fluctuations of mood are not as frequent or severe as the depressed mood in Dysthymic Disorder and there is no interference with social functioning.

Chronic mental disorders such as Obsessive Compulsive Disorder or Alcohol Dependence, when associated with depressive symptoms may suggest Dysthymic Disorder. The additional diagnosis of Dysthymic Disorder should be made only if the depressed mood, by virtue of its intensity or effect on functioning, can be clearly distinguished from the individual's usual mood. In children Dysthymic Disorder may be superimposed on **Attention Deficit Disorder,** a **Specific Developmental Disorder,** or an **Organic Mental Disorder.**

Diagnostic criteria for Dysthymic Disorder

A. During the past two years (or one year for children and adolescents) the individual has been bothered most or all of the time by symptoms characteristic of the depressive syndrome but that are not of sufficient severity and duration to meet the criteria for a major depressive episode.

B. The manifestations of the depressive syndrome may be relatively persistent or separated by periods of normal mood lasting a few days to a few weeks, but no more than a few months at a time.

C. During the depressive periods there is either prominent depressed mood (e.g., sad, blue, down in the dumps, low) or marked loss of interest or pleasure in all, or almost all, usual activities and pastimes.

D. During the depressive periods at least three of the following symptoms are present:

(1) insomnia or hypersomnia
(2) low energy level or chronic tiredness
(3) feelings of inadequacy, loss of self-esteem, or self-deprecation
(4) decreased effectiveness or productivity at school, work, or home
(5) decreased attention, concentration, or ability to think clearly
(6) social withdrawal
(7) loss of interest in or enjoyment of pleasurable activities
(8) irritability or excessive anger (in children, expressed toward parents or caretakers)
(9) inability to respond with apparent pleasure to praise or rewards
(10) less active or talkative than usual, or feels slowed down or restless
(11) pessimistic attitude toward the future, brooding about past events, or feeling sorry for self
(12) tearfulness or crying
(13) recurrent thoughts of death or suicide

E. Absence of psychotic features, such as delusions, hallucinations, or incoherence, or loosening of associations.

F. If the disturbance is superimposed on a preexisting mental disorder, such as Obsessive Compulsive Disorder or Alcohol Dependence, the depressed mood, by virtue of its intensity or effect on functioning, can be clearly distinguished from the individual's usual mood.

ATYPICAL AFFECTIVE DISORDERS

296.70 Atypical Bipolar Disorder

This is a residual category for individuals with manic features that cannot be classified as Bipolar Disorder or as Cyclothymic Disorder. For example, an individual who previously had a major depressive episode and now has an episode of illness with some manic features (hypomanic episode), but not of sufficient severity and duration to meet the criteria for a manic episode. Such cases have been referred to as "Bipolar II."

296.82 Atypical Depression

This is a residual category for individuals with depressive symptoms who cannot be diagnosed as having a Major or Other Specific Affective Disorder or Adjustment Disorder. Examples include the following:

(1) A distinct and sustained episode of the full depressive syndrome in an individual with Schizophrenia, Residual Type, that develops without an activation of the psychotic symptoms.

(2) A disorder that fulfills the criteria for Dysthymic Disorder; however, there have been intermittent periods of normal mood lasting more than a few months.

(3) A brief episode of depression that does not meet the criteria for a Major Affective Disorder and that is apparently not reactive to psychosocial stress, so that it cannot be classified as an Adjustment Disorder.

Anxiety Disorders

In this group of disorders anxiety is either the predominant disturbance, as in Panic Disorder and Generalized Anxiety Disorder, or anxiety is experienced if the individual attempts to master the symptoms, as in confronting the dreaded object or situation in a Phobic Disorder or resisting the obsessions or compulsions in Obsessive Compulsive Disorder. Diagnosis of an Anxiety Disorder is not made if the anxiety is due to another disorder, such as Schizophrenia, an Affective Disorder, or an Organic Mental Disorder.

It has been estimated that from 2% to 4% of the general population has at some time had a disorder that this manual would classify as an Anxiety Disorder.

Panic Disorder, Phobic Disorders and Obsessive Compulsive Disorder are each apparently more common among family members of individuals with each of these disorders than in the general population.

PHOBIC DISORDERS (OR PHOBIC NEUROSES)

The essential feature is persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (the phobic stimulus). The fear is recognized by the individual as excessive or unreasonable in proportion to the actual dangerousness of the object, activity, or situation.

Irrational avoidance of objects, activities, or situations that has an insignificant effect on life adjustment is commonplace. For example, many individuals experience some irrational fear when unable to avoid contact with harmless insects or spiders, but this has no major effect on their lives. However, when the avoidance behavior or fear is a significant source of distress to the individual or interferes with social or role functioning, a diagnosis of a Phobic Disorder is warranted.

The Phobic Disorders are subdivided into three types: Agoraphobia, the most severe and pervasive form; Social Phobia; and Simple Phobia. Both Social and Simple Phobias generally involve a circumscribed stimulus, but Simple Phobia tends to have an earlier onset and better prognosis. When more than one type is present, multiple diagnoses should be made.

Although anxiety related to separation from parental figures is a form of phobic reaction, it is classified as Separation Anxiety Disorder, in the section Disorders Usually First Evident in Infancy, Childhood, or Adolescence (p. 50). Similarly, phobic avoidance limited to sexual activities is classified as a Psychosexual Disorder Not Elsewhere Classified (p. 282).

Although Simple Phobia is the most common type of Phobic Disorder in

the general population, Agoraphobia is the most common among those seeking treatment.

300.21 Agoraphobia with Panic Attacks

300.22 Agoraphobia without Panic Attacks

The essential feature is a marked fear of being alone, or being in public places from which escape might be difficult or help not available in case of sudden incapacitation. Normal activities are increasingly constricted as the fears or avoidance behavior dominate the individual's life. The most common situations avoided involve being in crowds, such as on a busy street or in crowded stores, or being in tunnels, on bridges, on elevators, or on public transportation. Often these individuals insist that a family member or friend accompany them whenever they leave home.

The disturbance is not due to a major depressive episode, Obsessive Compulsive Disorder, Paranoid Personality Disorder, or Schizophrenia.

Often the initial phase of the disorder consists of recurrent panic attacks. (For a description of panic attacks, see p. 230.) The individual develops anticipatory fear of having such an attack and becomes reluctant or refuses to enter a variety of situations that are associated with these attacks. When there is a history of panic attacks (which may or may not be currently present) associated with avoidance behavior, the diagnosis of Agoraphobia with Panic Attacks should be made. Where there is no such history (or this information is lacking), the diagnosis of Agoraphobia without Panic Attacks should be made.

Associated features. Depression, anxiety, rituals, minor "checking" compulsions, or rumination is frequently present.

Age at onset. Most frequently the onset is in the late teens or early 20s, but it can be much later.

Course. The severity of the disturbance waxes and wanes, and periods of complete remission are possible. The activities or situations that the individual dreads may change from day to day.

Impairment. During exacerbations of the illness the individual may be housebound. The avoidance of certain situations, such as being in elevators, may grossly interfere with social and occupational functioning.

Complications. Some individuals attempt to relieve their anxiety with alcohol, barbiturates, or antianxiety medications even to the extent of becoming physiologically dependent on them. Major Depression is another complication.

Predisposing factors. Separation Anxiety Disorder in childhood and sudden object loss apparently predispose to the development of Agoraphobia.

Prevalence. A study of the general population in a small city found that approximately 0.5% of the population had had Agoraphobia at some time.

Sex ratio. The disorder is more frequently diagnosed in women.

Differential diagnosis. In Schizophrenia, Major Depression, Obsessive Compulsive Disorder and **Paranoid Personality Disorder** there may be phobic avoidance of certain situations. The diagnosis of Agoraphobia is not made if a phobia is due to any of these disorders.

Diagnostic criteria for Agoraphobia

A. The individual has marked fear of and thus avoids being alone or in public places from which escape might be difficult or help not available in case of sudden incapacitation, e.g., crowds, tunnels, bridges, public transportation.

B. There is increasing constriction of normal activities until the fears or avoidance behavior dominate the individual's life.

C. Not due to a major depressive episode, Obsessive Compulsive Disorder, Paranoid Personality Disorder, or Schizophrenia.

300.23 Social Phobia

The essential feature is a persistent, irrational fear of, and compelling desire to avoid, situations in which the individual may be exposed to scrutiny by others. There is also fear that the individual may behave in a manner that will be humiliating or embarrassing. Marked anticipatory anxiety occurs if the individual is confronted with the necessity of entering into such a situation, and he or she therefore attempts to avoid it. The disturbance is a significant source of distress and is recognized by the individual as excessive or unreasonable. It is not due to any other mental disorder. Examples of Social Phobias are fears of speaking or performing in public, using public lavatories, eating in public, and writing in the presence of others. Generally an individual has only one Social Phobia.

Usually the individual is aware that the fear is that others will detect signs of anxiety in the phobic situation. For example, the individual with a fear of writing in the presence of others is concerned that others may detect a hand tremor. A vicious cycle may be created in which the irrational fear generates anxiety that impairs performance, thus providing an apparent justification for avoiding the phobic situation.

Associated features. Considerable unfocused or generalized anxiety may also be present. Agoraphobia or Simple Phobia may coexist with Social Phobia.

Age at onset. The disorder often begins in late childhood or early adolescence.

Course. The disorder is usually chronic, and may undergo exacerbation

when the anxiety impairs performance of the feared activity. This then leads to increased anxiety, which strengthens the phobic avoidance.

Impairment. Unless the disorder is severe, it is rarely, in itself, incapacitating. However, considerable inconvenience may result from the need to avoid the phobic situation, e.g., avoiding a trip if it would necessitate the use of a public lavatory. Fear of public speaking may interfere with professional advancement.

Complications. Individuals with this disorder are prone to the episodic abuse of alcohol, barbiturates, and antianxiety medications, which they may use to relieve their anxiety.

Prevalence. The disorder is apparently relatively rare.

Predisposing factors, sex ratio, and familial pattern. No information.

Differential diagnosis. Avoidance of certain social situations that are normally a source of some distress, which is common in many individuals with "normal" fear of public speaking, does not justify a diagnosis of Social Phobia. In **Schizophrenia, Major Depression, Obsessive Compulsive Disorder,** and **Paranoid** and **Avoidant Personality Disorders,** there may be marked anxiety and avoidance of certain social situations. However, the diagnosis of Social Phobia is not made if the phobia is due to any of these disorders.

In **Simple Phobia** there is also a circumscribed phobic stimulus, but it is not a social situation involving the possibility of humiliation or embarrassment.

Diagnostic criteria for Social Phobia

A. A persistent, irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing.

B. Significant distress because of the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.

C. Not due to another mental disorder, such as Major Depression or Avoidant Personality Disorder.

300.29 Simple Phobia

The essential feature is a persistent, irrational fear of, and compelling desire to avoid, an object or a situation other than being alone or in public places away from home (Agoraphobia), or of humiliation or embarrassment in certain social situations (Social Phobia). Thus, this is a residual category of Phobic Disorder. This disturbance is a significant source of distress, and the individual recognizes

that his or her fear is excessive or unreasonable. The disturbance is not due to another mental disorder.

Simple Phobias are sometimes referred to as "specific" phobias. The most common Simple Phobias in the general population, though not necessarily among those seeking treatment, involve animals, particularly dogs, snakes, insects, and mice. Other Simple Phobias are claustrophobia (fear of closed spaces) and acrophobia (fear of heights).

Associated features. When suddenly exposed to the phobic stimulus, the individual becomes overwhelmingly fearful and may experience symptoms identical with those of a panic attack (p. 230). Because of anticipatory anxiety, the individual will often try to gain considerable information before entering situations in which the phobic stimulus may be encountered.

Age at onset. Age at onset varies, but animal phobias nearly always begin in childhood.

Course. Most simple phobias that start in childhood disappear without treatment. However, those that persist into adulthood rarely remit without treatment.

Impairment. Impairment may be minimal if the phobic object is rare and easily avoided, such as fear of snakes in someone living in the city. Impairment may be considerable if the phobic object is common and cannot be avoided, such as a fear of elevators in someone living in a large city who must use elevators at work.

Complications and predisposing factors. No information.

Prevalence. Simple Phobias may be common; but since they rarely result in marked impairment, individuals with Simple Phobia rarely seek treatment.

Sex ratio. The disorder is more often diagnosed in women.

Differential diagnosis. In **Schizophrenia** certain activities may be avoided in response to delusions. Similarly, in **Obsessive Compulsive Disorder** phobic avoidance of certain situations that are associated with anxiety about dirt or contamination is frequent. The diagnosis of Simple Phobia should not be made in either case.

Diagnostic criteria for Simple Phobia

A. A persistent, irrational fear of, and compelling desire to avoid, an object or a situation other than being alone, or in public places away from home (Agoraphobia), or of humiliation or embarrassment in certain social situations (Social Phobia). Phobic objects are often animals, and phobic situations frequently involve heights or closed spaces.

B. Significant distress from the disturbance and recognition by the individual that his or her fear is excessive or unreasonable.

C. Not due to another mental disorder, such as Schizophrenia or Obsessive Compulsive Disorder.

ANXIETY STATES (OR ANXIETY NEUROSES)

300.01 Panic Disorder

The essential features are recurrent panic (anxiety) attacks that occur at times unpredictably, though certain situations, e.g., driving a car, may become associated with a panic attack. The same clinical picture occurring during marked physical exertion or a life-threatening situation is not termed a panic attack.

The panic attacks are manifested by the sudden onset of intense apprehension, fear, or terror, often associated with feelings of impending doom. The most common symptoms experienced during an attack are dyspnea; palpitations; chest pain or discomfort; choking or smothering sensations; dizziness, vertigo, or unsteady feelings; feelings of unreality (depersonalization or derealization); paresthesias; hot and cold flashes; sweating; faintness; trembling or shaking; and fear of dying, going crazy, or doing something uncontrolled during the attack. Attacks usually last minutes; more rarely, hours.

A common complication of this disorder is the development of an anticipatory fear of helplessness or loss of control during a panic attack, so that the individual becomes reluctant to be alone or in public places away from home. When many situations of the kind are avoided the diagnosis of Agoraphobia with Panic Attacks should be made (p. 226) rather than Panic Disorder.

Associated features. The individual often develops varying degrees of nervousness and apprehension between attacks. This nervousness and apprehension is characterized by the usual manifestations of apprehensive expectation, vigilance and scanning, motor tension, and autonomic hyperactivity.

Age at onset. The disorder often begins in late adolescence or early adult life, but may occur initially in mid-adult life.

Course. The disorder may be limited to a single brief period lasting several weeks or months, recur several times, or become chronic.

Impairment. Except when the disorder is severe or complicated by Agoraphobia, it is rarely incapacitating.

Complications. The complication of Agoraphobia with Panic Attacks has been mentioned above. Other complications include abuse of alcohol and antianxiety medications, and Depressive Disorders.

Predisposing factors. Separation Anxiety Disorder in childhood and sudden object loss apparently predispose to the development of this disorder.

Prevalence. The disorder is apparently common.

Sex ratio. This condition is diagnosed much more commonly in women.

Differential diagnosis. Physical disorders such as **hypoglycemia, pheochromocytoma,** and **hyperthyroidism,** all of which can cause similar symptoms, must be ruled out.

In **Withdrawal** from some substances, such as **barbiturates,** and in some **Substance Intoxications,** such as due to **caffeine** or **amphetamines,** there may be panic attacks. Panic Disorder should not be diagnosed when the panic attacks are due to Substance-induced Organic Mental Disorder.

In **Schizophrenia, Major Depression,** or **Somatization Disorder** panic attacks may occur. However, the diagnosis of Panic Disorder is not made if the panic attacks are due to these other disorders.

Generalized Anxiety Disorder may be confused with the chronic anxiety that often develops between panic attacks in Panic Disorder. A history of recurrent panic attacks precludes Generalized Anxiety Disorder.

In **Simple** or **Social Phobia,** the individual may develop panic attacks if exposed to the phobic stimulus. However, in Panic Disorder, the individual is never certain which situations provoke panic attacks.

Diagnostic criteria for Panic Disorder

A. At least three panic attacks within a three-week period in circumstances other than during marked physical exertion or in a life-threatening situation. The attacks are not precipitated only by exposure to a circumscribed phobic stimulus.

B. Panic attacks are manifested by discrete periods of apprehension or fear, and at least four of the following symptoms appear during each attack:

(1) dyspnea
(2) palpitations
(3) chest pain or discomfort
(4) choking or smothering sensations
(5) dizziness, vertigo, or unsteady feelings
(6) feelings of unreality
(7) paresthesias (tingling in hands or feet)
(8) hot and cold flashes
(9) sweating
(10) faintness
(11) trembling or shaking

(12) fear of dying, going crazy, or doing something uncontrolled during an attack

C. Not due to a physical disorder or another mental disorder, such as Major Depression, Somatization Disorder, or Schizophrenia.

D. The disorder is not associated with Agoraphobia (p. 227).

300.02 Generalized Anxiety Disorder

The essential feature is generalized, persistent anxiety of at least one month's duration without the specific symptoms that characterize Phobic Disorders (phobias), Panic Disorder (panic attacks), or Obsessive Compulsive Disorder (obsessions or compulsions). The diagnosis is not made if the disturbance is due to another physical or mental disorder, such as hyperthyroidism or Major Depression.

Although the specific manifestations of the anxiety vary from individual to individual, generally there are signs of motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.

(1) *Motor tension.* Shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, and inability to relax are common complaints. There may also be eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle, and sighing respiration.

(2) *Autonomic hyperactivity.* There may be sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in the throat, flushing, pallor, and high resting pulse and respiration rate.

(3) *Apprehensive expectation.* The individual is generally apprehensive and continually feels anxious, worries, ruminates, and anticipates that something bad will happen to himself or herself (e.g., fear of fainting, losing control, dying) or to others (e.g., family members may become ill or injured in an accident).

(4) *Vigilance and scanning.* Apprehensive expectation may cause hyperattentiveness so that the individual feels "on edge," impatient, or irritable. There may be complaints of distractibility, difficulty in concentrating, insomnia, difficulty in falling asleep, interrupted sleep, and fatigue on awakening.

Associated features. Mild depressive symptoms are common.

Impairment. Impairment in social or occupational functioning is rarely more than mild.

Complications. Abuse of alcohol, barbiturates, and antianxiety medications is common.

Age at onset, course, predisposing factors, prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. Physical disorders, such as hyperthyroidism, and **Organic Mental Disorders, such as Caffeine Intoxication,** must be ruled out.

In **Adjustment Disorder with Anxious Mood,** the full symptom picture required to meet the criteria for Generalized Anxiety Disorder is generally not present, the duration of the disturbance is usually less than a month, and a psychosocial stressor must be recognized.

In **Schizophrenia, Depressive Disorders, Hypochondriasis, Obsessive Compulsive Disorder,** and many other mental disorders, generalized and persistent anxiety is often a prominent symptom. The diagnosis of Generalized Anxiety Disorder is not made if the anxiety is judged to be due to another mental disorder.

In **Panic Disorder** there is often severe chronic anxiety between panic attacks. If the panic attacks are overlooked, an incorrect diagnosis of Generalized Anxiety Disorder may be made.

Diagnostic criteria for Generalized Anxiety Disorder

A. Generalized, persistent anxiety is manifested by symptoms from three of the following four categories:

(1) motor tension: shakiness, jitteriness, jumpiness, trembling, tension, muscle aches, fatigability, inability to relax, eyelid twitch, furrowed brow, strained face, fidgeting, restlessness, easy startle

(2) autonomic hyperactivity: sweating, heart pounding or racing, cold, clammy hands, dry mouth, dizziness, light-headedness, paresthesias (tingling in hands or feet), upset stomach, hot or cold spells, frequent urination, diarrhea, discomfort in the pit of the stomach, lump in the throat, flushing, pallor, high resting pulse and respiration rate

(3) apprehensive expectation: anxiety, worry, fear, rumination, and anticipation of misfortune to self or others

(4) vigilance and scanning: hyperattentiveness resulting in distractibility, difficulty in concentrating, insomnia, feeling "on edge," irritability, impatience

B. The anxious mood has been continuous for at least one month.

C. Not due to another mental disorder, such as a Depressive Disorder or Schizophrenia.

D. At least 18 years of age.

300.30 Obsessive Compulsive Disorder (or Obsessive Compulsive Neurosis)
The essential features are recurrent obsessions or compulsions. *Obsessions* are recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, that is, they are not experienced as voluntarily produced, but rather as thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts are made to ignore or suppress them. *Compulsions* are repetitive and seemingly purposeful behaviors that are performed according to certain rules or in a stereotyped fashion. The behavior is not an end in itself, but is designed to produce or to prevent some future event or situation. However, the activity is not connected in a realistic way with what it is designed to produce or prevent, or may be clearly excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist the compulsion (at least initially). The individual generally recognizes the senselessness of the behavior (this may not be true for young children) and does not derive pleasure from carrying out the activity, although it provides a release of tension.

The most common obsessions are repetitive thoughts of violence (e.g., killing one's child), contamination (e.g., becoming infected by shaking hands), and doubt (e.g., repeatedly wondering whether one has performed some action, such as having hurt someone in a traffic accident). The most common compulsions involve hand-washing, counting, checking, and touching.

When the individual attempts to resist a compulsion, there is a sense of mounting tension that can be immediately relieved by yielding to the compulsion. In the course of the illness, after repeated failure at resisting the compulsions, the individual may give in to them and no longer experience a desire to resist them.

Associated features. Depression and anxiety are common. Frequently there is phobic avoidance of situations that involve the content of the obsessions, such as dirt or contamination.

Age at onset. Although the disorder usually begins in adolescence or early adulthood, it may begin in childhood.

Course. The course is usually chronic, with waxing and waning of symptoms.

Impairment. Impairment is generally moderate to severe. In some cases compulsions may become the major life activity.

Complications. Complications include Major Depression and the abuse of alcohol and antianxiety medications.

Predisposing factors. No information.

Prevalence. The disorder is apparently rare in the general population.

Sex ratio. This disorder is equally common in males and in females.

Differential diagnosis. Some activities, such as **eating, sexual behavior (e.g., Paraphilias), gambling, or drinking, when engaged in excessively** may be referred to as "compulsive". However, these activities are not true compulsions, because the individual derives pleasure from the particular activity and may wish to resist it only because of its secondary deleterious consequences.

Obsessive brooding, rumination or **preoccupation,** i.e., excessive and repetitive thinking about real or potentially unpleasant circumstances, or indecisive consideration of alternatives lacks the quality of being ego-dystonic, because the individual generally regards the ideation as meaningful, although possibly excessive. Therefore, these are not true obsessions.

In **Schizophrenia,** stereotyped behavior is common, but can be explained by delusions rather than as being ego-dystonic. Obsessions and compulsions sometimes occur transiently during the prodromal phase of Schizophrenia. In such cases the diagnosis of Obsessive Compulsive Disorder is not made. **Tourette's Disorder, Schizophrenia, Major Depression** and, very rarely, **Organic Mental Disorder** may have obsessions and compulsions as symptoms, but in such instances the diagnosis Obsessive Compulsive Disorder is not made. However, Obsessive Compulsive Disorder may precede the development of a Major Depression, in which case both diagnoses should be recorded.

Diagnostic criteria for Obsessive Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions: recurrent, persistent ideas, thoughts, images, or impulses that are ego-dystonic, i.e., they are not experienced as voluntarily produced, but rather as thoughts that invade consciousness and are experienced as senseless or repugnant. Attempts are made to ignore or suppress them.

Compulsions: repetitive and seemingly purposeful behaviors that are performed according to certain rules or in a stereotyped fashion. The behavior is not an end in itself, but is designed to produce or prevent some future event or situation. However, either the activity is not connected in a realistic way with what it is designed to produce or prevent, or may be clearly excessive. The act is performed with a sense of subjective compulsion coupled with a desire to resist the compulsion (at least initially). The individual generally recognizes the senselessness of the behavior (this may not be true for young children) and does not derive pleasure from carrying out the activity, although it provides a release of tension.

B. The obsessions or compulsions are a significant source of distress to the individual or interfere with social or role functioning.

C. Not due to another mental disorder, such as Tourette's Disorder, Schizophrenia, Major Depression, or Organic Mental Disorder.

308.30 Post-traumatic Stress Disorder, Acute

309.81 Post-traumatic Stress Disorder, Chronic or Delayed

The essential feature is the development of characteristic symptoms following a psychologically traumatic event that is generally outside the range of usual human experience.

The characteristic symptoms involve reexperiencing the traumatic event; numbing of responsiveness to, or reduced involvement with, the external world; and a variety of autonomic, dysphoric, or cognitive symptoms.

The stressor producing this syndrome would evoke significant symptoms of distress in most people, and is generally outside the range of such common experiences as simple bereavement, chronic illness, business losses, or marital conflict. The trauma may be experienced alone (rape or assault) or in the company of groups of people (military combat). Stressors producing this disorder include natural disasters (floods, earthquakes), accidental man-made disasters (car accidents with serious physical injury, airplane crashes, large fires), or deliberate man-made disasters (bombing, torture, death camps). Some stressors frequently produce the disorder (e.g., torture) and others produce it only occasionally (e.g., car accidents). Frequently there is a concomitant physical component to the trauma which may even involve direct damage to the central nervous system (e.g., malnutrition, head trauma). The disorder is apparently more severe and longer lasting when the stressor is of human design. The severity of the stressor should be recorded and the specific stressor may be noted on Axis IV (p. 26).

The traumatic event can be reexperienced in a variety of ways. Commonly the individual has recurrent painful, intrusive recollections of the event or recurrent dreams or nightmares during which the event is reexperienced. In rare instances there are dissociativelike states, lasting from a few minutes to several hours or even days, during which components of the event are relived and the individual behaves as though experiencing the event at that moment. Such states have been reported in combat veterans. Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. A person may complain of feeling detached or estranged from other people, that he or she has lost the ability to become interested in previously enjoyed significant activities, or that the ability to feel emotions of any type, especially those associated with intimacy, tenderness, and sexuality, is markedly decreased.

After experiencing the stressor, many develop symptoms of excessive autonomic arousal, such as hyperalertness, exaggerated startle response, and difficulty falling asleep. Recurrent nightmares during which the traumatic event is relived and which are sometimes accompanied by middle or terminal sleep disturbance may be present. Some complain of impaired memory or difficulty in concentrating or completing tasks. In the case of a life-threatening trauma shared with others, survivors often describe painful guilt feelings about surviving when many did not, or about the things they had to do in order to survive. Activities or situations that may arouse recollections of the traumatic event are

often avoided. Symptoms characteristic of Post-traumatic Stress Disorder are often intensified when the individual is exposed to situations or activities that resemble or symbolize the original trauma (e.g., cold snowy weather or uniformed guards for death-camp survivors, hot, humid weather for veterans of the South Pacific).

Associated features. Symptoms of depression and anxiety are common, and in some instances may be sufficiently severe to be diagnosed as an Anxiety or Depressive Disorder. Increased irritability may be associated with sporadic and unpredictable explosions of aggressive behavior, upon even minimal or no provocation. The latter symptom has been reported to be particularly characteristic of war veterans with this disorder. Impulsive behavior can occur, such as sudden trips, unexplained absences, or changes in life-style or residence. Survivors of death camps sometimes have symptoms of an Organic Mental Disorder, such as failing memory, difficulty in concentrating, emotional lability, autonomic lability, headache, and vertigo.

Age at onset. The disorder can occur at any age, including during childhood.

Course and subtypes. Symptoms may begin immediately or soon after the trauma. It is not unusual, however, for the symptoms to emerge after a latency period of months or years following the trauma.

When the symptoms begin within six months of the trauma and have not lasted more than six months, the acute subtype is diagnosed, and the prognosis for remission is good. If the symptoms either develop more than six months after the trauma or last six months or more, the chronic or delayed subtype is diagnosed.

Impairment and complications. Impairment may either be mild or affect nearly every aspect of life. Phobic avoidance of situations or activities resembling or symbolizing the original trauma may result in occupational or recreational impairment. "Psychic numbing" may interfere with interpersonal relationships, such as marriage or family life. Emotional lability, depression, and guilt may result in self-defeating behavior or suicidal actions. Substance Use Disorders may develop.

Predisposing factors. Preexisting psychopathology apparently predisposes to the development of the disorder.

Prevalence. No information.

Sex ratio and familial pattern. No information.

Differential diagnosis. If an **Anxiety, Depressive,** or **Organic Mental Disorder** develops following the trauma, these diagnoses should also be made.

In **Adjustment Disorder,** the stressor is usually less severe and within the range of common experience; and the characteristic symptoms of Post-traumatic Stress Disorder, such as reexperiencing the trauma, are absent.

Diagnostic criteria for Post-traumatic Stress Disorder

A. Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone.

B. Reexperiencing of the trauma as evidenced by at least one of the following:

(1) recurrent and intrusive recollections of the event
(2) recurrent dreams of the event
(3) sudden acting or feeling as if the traumatic event were reoccurring, because of an association with an environmental or ideational stimulus

C. Numbing of responsiveness to or reduced involvement with the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) markedly diminished interest in one or more significant activities
(2) feeling of detachment or estrangement from others
(3) constricted affect

D. At least two of the following symptoms that were not present before the trauma:

(1) hyperalertness or exaggerated startle response
(2) sleep disturbance
(3) guilt about surviving when others have not, or about behavior required for survival
(4) memory impairment or trouble concentrating
(5) avoidance of activities that arouse recollection of the traumatic event
(6) intensification of symptoms by exposure to events that symbolize or resemble the traumatic event

SUBTYPES

Post-traumatic Stress Disorder, Acute

A. Onset of symptoms within six months of the trauma.

B. Duration of symptoms less than six months.

Post-traumatic Stress Disorder, Chronic or Delayed

Either of the following, or both:

(1) duration of symptoms six months or more (chronic)
(2) onset of symptoms at least six months after the trauma (delayed)

300.00 Atypical Anxiety Disorder

This category should be used when the individual appears to have an Anxiety Disorder that does not meet the criteria for any of the above specified conditions.

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Somatoform Disorders

The essential features of this group of disorders are physical symptoms suggesting physical disorder (hence, Somatoform) for which there are no demonstrable organic findings or known physiological mechanisms and for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts. Unlike Factitious Disorder or Malingering, the symptom production in Somatoform Disorders is not under voluntary control, i.e., the individual does not experience the sense of controlling the production of the symptoms. Although the symptoms of Somatoform Disorders are "physical," the specific pathophysiological processes involved are not demonstrable or understandable by existing laboratory procedures and are conceptualized most clearly using psychological constructs. For that reason, these disorders are not classified as "physical disorders."

The first disorder in this category is Somatization Disorder, a common and chronic polysymptomatic disorder that begins early in life and that was previously referred to as either Hysteria or Briquet's Syndrome. The second disorder is Conversion Disorder, which, as defined here, is relatively uncommon. This diagnosis is to be used only when conversion symptoms are the predominant disturbance and are not symptomatic of another disorder. Psychogenic Pain Disorder is characterized by psychologically induced pain not attributable to any other mental or physical disorder. Hypochondriasis involves preoccupation with the fear or belief of having a serious disease. Finally, Atypical Somatoform Disorder is the term applied to physical symptoms without an organic basis that do not fit the criteria for any specific Somatoform Disorder.

300.81 Somatization Disorder

The essential features are recurrent and multiple somatic complaints of several years' duration for which medical attention has been sought but which are apparently not due to any physical disorder. The disorder begins before the age of 30 and has a chronic but fluctuating course.

Complaints are often presented in a dramatic, vague, or exaggerated way, or are part of a complicated medical history in which many physical diagnoses have been considered. The individuals frequently receive medical care from a number of physicians, sometimes simultaneously. (Although most people without mental disorders at various times have aches and pains and other physical complaints, they rarely bring them to medical attention.) Complaints invariably involve the following organ systems or types of symptoms: conversion or pseudoneurological (e.g., paralysis, blindness), gastrointestinal (e.g., abdominal pain), female reproductive (e.g., painful menstruation), psychosexual (e.g., sexual indifference), pain (e.g., back pain), and cardiopulmonary (e.g., dizziness).

Associated features. Anxiety and depressed mood are extremely common. In fact, many individuals with this disorder who seek mental health care do so because of the depressive symptoms, which include suicide threats and attempts. Antisocial behavior and occupational, interpersonal, and marital difficulties are common. Hallucinations are also reported; this is usually the hallucination of hearing one's name called without impairment of reality testing. Histrionic Personality Disorder and, more rarely, Antisocial Personality Disorder often are also present.

Age at onset. Symptoms usually begin in the teen years or, rarely, in the 20s. Menstrual difficulties may be one of the earliest symptoms in females, although preadolescents and adolescents may present with seizures, depressive symptoms, headache, abdominal pain, or a plethora of other physical symptoms.

Course. This is a chronic but fluctuating disorder that rarely remits spontaneously. A year seldom passes without some medical attention.

Impairment and complications. Because of constant seeking out of doctors, numerous medical evaluations are undergone, both in and out of the hospital; and there is frequently unwitting submission to unnecessary surgery. These individuals run the risk of Substance Use Disorders involving various prescribed medicines. Because of depressive symptoms, they may experience long periods of incapacity and frequent suicidal threats and attempts. Completed suicide, when it occurs, is usually associated with Substance Abuse. People with this disorder often lead lives as chaotic and complicated as their medical histories.

Predisposing factors. No information.

Prevalence and sex ratio. Approximately 1% of females have this disorder. The disorder is rarely diagnosed in males.

Familial pattern. This disorder and Antisocial Personality Disorder are more common among family members than in the general population.

Differential diagnosis. It is necessary to rule out **physical disorders that present with vague, multiple, and confusing somatic symptoms, e.g., hyperparathyroidism, porphyria, multiple sclerosis, and systemic lupus erythematosis.** The onset of multiple physical symptoms late in life is almost always due to physical disease.

Schizophrenia with multiple somatic delusions needs to be differentiated from the nondelusional somatic complaints of individuals with Somatization Disorder. Rarely, individuals with Somatization Disorder also have Schizophrenia, in which case both diagnoses should be noted.

Dysthymic Disorder and **Generalized Anxiety Disorder** are not diagnosed in individuals who have Somatization Disorder since mild depressive and anxiety symptoms are so ubiquitous in Somatization Disorder. On the other hand, a superimposed **Major Depression** should be diagnosed if there is a full and per-

sistent affective syndrome that can be clearly distinguished from the individual's usual condition.

In **Panic Disorder** there are also cardiopulmonary symptoms, but these occur only in the context of panic attacks. However, Panic Disorder may coexist with Somatization Disorder, in which case both diagnoses should be made.

In **Conversion Disorder** one or more conversion symptoms occur in the absence of the full clinical picture of Somatization Disorder.

In **Factitious Disorder with Physical Symptoms** the individual has voluntary control of the symptoms.

Diagnostic criteria for Somatization Disorder

A. A history of physical symptoms of several years' duration beginning before the age of 30.

B. Complaints of at least 14 symptoms for women and 12 for men, from the 37 symptoms listed below. To count a symptom as present the individual must report that the symptom caused him or her to take medicine (other than aspirin), alter his or her life pattern, or see a physician. The symptoms, in the judgment of the clinician, are not adequately explained by physical disorder or physical injury, and are not side effects of medication, drugs or alcohol. The clinician need not be convinced that the symptom was actually present, e.g., that the individual actually vomited throughout her entire pregnancy; report of the symptom by the individual is sufficient.

Sickly: Believes that he or she has been sickly for a good part of his or her life.

Conversion or pseudoneurological symptoms: Difficulty swallowing, loss of voice, deafness, double vision, blurred vision, blindness, fainting or loss of consciousness, memory loss, seizures or convulsions, trouble walking, paralysis or muscle weakness, urinary retention or difficulty urinating.

Gastrointestinal symptoms: Abdominal pain, nausea, vomiting spells (other than during pregnancy), bloating (gassy), intolerance (e.g., gets sick) of a variety of foods, diarrhea.

Female reproductive symptoms: Judged by the individual as occurring more frequently or severely than in most women: painful menstruation, menstrual irregularity, excessive bleeding, severe vomiting throughout pregnancy or causing hospitalization during pregnancy.

Psychosexual symptoms: For the major part of the individual's life after opportunities for sexual activity: sexual indifference, lack of pleasure during intercourse, pain during intercourse.

Pain: Pain in back, joints, extremities, genital area (other than during intercourse); pain on urination; other pain (other than headaches).

Cardiopulmonary symptoms: Shortness of breath, palpitations, chest pain, dizziness.

300.11 Conversion Disorder (or Hysterical Neurosis, Conversion Type)

The essential feature is a clinical picture in which the predominant disturbance is a loss of or alteration in physical functioning that suggests physical disorder but which instead is apparently an expression of a psychological conflict or need. The disturbance is not under voluntary control, and after appropriate investigation cannot be explained by any physical disorder or known pathophysiological mechanism. Conversion Disorder is not diagnosed when conversion symptoms are limited to pain (see Psychogenic Pain Disorder, p. 247) or to a disturbance in sexual functioning (see Psychosexual Dysfunctions, p. 275) or are part of Somatization Disorder (p. 241).

The most obvious and "classic" conversion symptoms are those that suggest neurological disease, such as paralysis, aphonia, seizures, coordination disturbance, akinesia, dyskinesia, blindness, tunnel vision, anosmia, anesthesia, and paresthesia. More rarely, conversion symptoms may involve the autonomic or endocrine system. Vomiting as a conversion symptom can represent revulsion and disgust. Pseudocyesis (false pregnancy) can represent both a wish for, and a fear of, pregnancy.

The definition of this disorder is unique in this classification in that it implies specific mechanisms to account for the disturbance. Two mechanisms have been suggested to explain what the individual derives from having a conversion symptom.

In one mechanism, the individual achieves "primary gain" by keeping an internal conflict or need out of awareness. In such cases there is a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom. For example, after an argument, inner conflict about the expression of rage may be expressed as "aphonia" or as a "paralysis" of the arm; or if the individual views a traumatic event, a conflict about acknowledging that event may be expressed as "blindness." In such cases the symptom has a symbolic value that is a representation and partial solution of the underlying psychological conflict.

In the other mechanism the individual achieves "secondary gain" by avoiding a particular activity that is noxious to him or her or by getting support from the environment that otherwise might not be forthcoming. For example, with a "paralyzed" hand a soldier can avoid firing a gun; or a person with marked dependency needs may develop "blindness" or inability to walk or stand, even though all leg movements can be performed normally (astasia-abasia), to prevent desertion by a spouse.

A conversion symptom is likely to involve a single symptom during a given episode, but may vary in site and nature if there are subsequent episodes.

Associated features. Usually the symptom develops in a setting of extreme psychological stress and appears suddenly. Histrionic personality traits (see p. 313) are common, but not invariably present. "La belle indifference," an attitude toward the symptom that suggests a relative lack of concern, out of keeping with the severe nature of the impairment, is sometimes present. This feature has little diagnostic value, however, since it is also found in some seriously ill medical patients who are stoic about their situation.

Age at onset. The usual age at onset is adolescence or early adulthood, but the symptom may appear for the first time during middle age or even in the later decades of life.

Course. The course of Conversion Disorder (as distinct from conversion symptoms that are part of other disorders, such as Somatization Disorder) is unknown, but probably is usually of short duration, with abrupt onset and resolution. Some individuals given an initial diagnosis of conversion symptoms are later found to have a neurological disorder. Apparently, in some of these instances the earliest symptoms of the neurological disorder predisposed to the development of a concomitant conversion symptom. In other instances the original diagnosis of a conversion symptom was incorrect and represented a missed diagnosis of true organic pathology.

Impairment and complications. The effect of the disorder on the individual's life is usually marked and frequently prevents normal life activities. Prolonged loss of function may produce real and serious complications, such as contractures or disuse atrophy from conversion paralysis. When associated with Dependent Personality Disorder, the conversion symptom may enhance the development of a chronic sick role. Unnecessary diagnostic or therapeutic medical procedures may themselves produce disfigurement or incapacity.

Predisposing factors. Antecedent physical disorder (which may provide a prototype for the symptoms, e.g., pseudoseizures in individuals with epilepsy), exposure to other individuals with real physical symptoms or conversion symptoms, and extreme psychosocial stress (e.g., warfare or the recent death of a significant figure) are predisposing factors. Histrionic and Dependent Personality Disorders also predispose to the development of the disorder.

Prevalence. Although Conversion Disorder was apparently common several decades ago, it is now rarely encountered. Most cases are seen on neurology or orthopedic wards and in military settings, especially in time of warfare.

Sex ratio. No definite information is available; but one particular conversion symptom, globus hystericus, the feeling of a lump in the throat that interferes with swallowing, is apparently more common in women.

Familial pattern. No information.

Differential diagnosis. Some **physical disorders that present with vague, multiple, somatic symptoms, such as multiple sclerosis or systemic lupus erythematosis,** may early in their course be misdiagnosed as conversion symptoms. A diagnosis of Conversion Disorder is suggested if the symptoms are inconsistent with the actual known physical disorder—for example, motor signs of good function in a supposedly paralyzed part, or complaints obviously inconsistent with the anatomic distribution of the nervous system. Another example would be "anesthesia" of the hand conforming to the concept of the hand rather than to the functional area served by a specific part of the nervous system. In another example, an individual with conversion blindness may be found to have normal pupillary responses and evoked potentials as measured by an EEG. Resolution of symptoms through suggestion, hypnosis, or narcoanalysis suggests a conversion symptom. Temporary improvement due to suggestion has little diagnostic value since this may also occur with true physical illness.

In **undiagnosed physical disorder** physical symptoms are present that are not explained by a known physical disorder, but there is no evidence that the symptom serves a psychological purpose. **Physical disorders in which psychological factors often play an important role, such as irritable colon or bronchial asthma,** should not be diagnosed as Conversion Disorders, since demonstrable organic pathology or a pathophysiological mechanism that accounts for the disorder is present.

Somatization Disorder and, more rarely, **Schizophrenia** may have conversion *symptoms*. However, the diagnosis of Conversion Disorder should not be made when such symptoms are due to either of these more pervasive disorders.

For many of the **Psychosexual Dysfunctions,** it is difficult to determine whether the symptom, such as impotence in the male or lack of sexual excitement in the female, represents a physiological reaction to anxiety or a direct expression of a psychological conflict or need (conversion symptom). For this reason, and in order to group all of the sexual disturbances together, conversion symptoms involving sexual dysfunction are not coded as Conversion Disorder, but rather as Psychosexual Dysfunction.

Some **psychogenic pain** can be conceptualized as a conversion symptom; but because of the different course and treatment implications, all such cases should be coded as Psychogenic Pain Disorder.

In **Hypochondriasis** typically there are physical symptoms, but there is no actual loss or distortion of bodily function.

In **Factitious Disorder with Physical Symptoms,** the symptoms are, by definition, under voluntary control; and the simulated illness rarely takes the form of neurological symptoms that are likely to be confused with conversion symptoms. However, distinguishing conversion seizures from seizures as a manifestation of Factitious Disorder is often extremely difficult.

In **Malingering** the symptom production is under the individual's voluntary control and is in pursuit of a goal that is obviously recognizable given the individual's environmental circumstance; this goal frequently involves the prospect of material reward or the avoidance of unpleasant work or duty.

Diagnostic criteria for Conversion Disorder

A. The predominant disturbance is a loss of or alteration in physical functioning suggesting a physical disorder.

B. Psychological factors are judged to be etiologically involved in the symptom, as evidenced by one of the following:

(1) there is a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the symptom
(2) the symptom enables the individual to avoid some activity that is noxious to him or her
(3) the symptom enables the individual to get support from the environment that otherwise might not be forthcoming

C. It has been determined that the symptom is *not* under voluntary control.

D. The symptom cannot, after appropriate investigation, be explained by a known physical disorder or pathophysiological mechanism.

E. The symptom is not limited to pain or to a disturbance in sexual functioning.

F. Not due to Somatization Disorder or Schizophrenia.

307.80 Psychogenic Pain Disorder

The essential feature is a clinical picture in which the predominant feature is the complaint of pain, in the absence of adequate physical findings and in association with evidence of the etiological role of psychological factors. The disturbance is not due to any other mental disorder.

The pain symptom either is inconsistent with the anatomic distribution of the nervous system or, if it mimics a known disease entity (as in angina or sciatica), cannot be adequately accounted for by organic pathology, after extensive diagnostic evaluation. Similarly, no pathophysiological mechanism accounts for the pain, as in tension headaches caused by muscle spasm.

That psychological factors are etiologically involved in the pain may be evidenced by a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the pain, or by the pain's permitting the individual to avoid some activity that is noxious to him or her or to get support from the environment that otherwise might not be forthcoming.

Associated features. Psychogenic Pain Disorder may be accompanied by other localized sensory or motor function changes, such as paresthesias and muscle spasm. There often are frequent visits to physicians to obtain relief

despite medical reassurance (doctor-shopping), excessive use of analgesics without relief of the pain, requests for surgery, and the assumption of an invalid role. The individual usually refuses to consider the role of psychological factors in the pain. In some cases the pain has symbolic significance, such as pain mimicking angina in an individual whose father died from heart disease. A past history of conversion symptoms is common. Histrionic personality traits (see p. 313) are seldom present, nor is "la belle indifference," though concern about the pain symptom is usually less intense than its stated severity. Dysphoric moods are common.

Age at onset. This disorder can occur at any stage of life, from childhood to old age, but it seems to begin most frequently in adolescence or early adulthood.

Course. The pain usually appears suddenly and increases in severity over a few days or weeks. The symptom may subside with appropriate intervention or termination of a precipitating event, or it may persist for months or years if reinforced.

Impairment. This varies with the intensity and duration of the pain and may range from a slight disturbance of social or occupational functioning to total incapacity and need for hospitalization.

Complications. The most serious complications are iatrogenic; they include dependence on minor tranquilizers and narcotic analgesics and repeated, unsuccessful, surgical intervention.

Predisposing factors. Severe psychosocial stress is a predisposing factor.

Prevalence. No information, although the disorder is probably common in general medical practice.

Sex ratio. The disorder is more frequently diagnosed in women.

Familial pattern. Relatives of individuals with this disorder have had more painful injuries and illnesses than occur in the general population.

Differential diagnosis. The **dramatic presentation of organic pain**, which may seem excessive to an observer because of only slight physical findings, is not sufficient for diagnosing the disorder, and may be only a function of histrionic personality traits or a cultural style of communication.

Individuals with **Somatization Disorder, Depressive Disorders,** or **Schizophrenia** may complain of various aches and pains, but the pain rarely dominates the clinical picture, and Psychogenic Pain Disorder should not be diagnosed if the pain is due to any other mental disorder.

In **Malingering**, the symptom production is under the individual's voluntary control, and is in pursuit of a goal that is obviously recognizable given the

individual's environmental circumstances. For example, an individual with Opioid Dependence complains of pain in order to obtain opioids.

The **pain associated with muscle contraction headaches ("tension headaches")** is not to be diagnosed as Psychogenic Pain Disorder because there is a pathophysiological mechanism that accounts for the pain.

Complete disappearance of pain through suggestion, hypnosis, or narcoanalysis suggests Psychogenic Pain Disorder. Temporary improvement due to suggestion has little diagnostic value since it may also occur in true physical illness.

Diagnostic criteria for Psychogenic Pain Disorder

A. Severe and prolonged pain is the predominant disturbance.

B. The pain presented as a symptom is inconsistent with the anatomic distribution of the nervous system; after extensive evaluation, no organic pathology or pathophysiological mechanism can be found to account for the pain; or, when there is some related organic pathology, the complaint of pain is grossly in excess of what would be expected from the physical findings.

C. Psychological factors are judged to be etiologically involved in the pain, as evidenced by at least one of the following:

(1) a temporal relationship between an environmental stimulus that is apparently related to a psychological conflict or need and the initiation or exacerbation of the pain

(2) the pain's enabling the individual to avoid some activity that is noxious to him or her

(3) the pain's enabling the individual to get support from the environment that otherwise might not be forthcoming

D. Not due to another mental disorder.

300.70 Hypochondriasis (or Hypochondriacal Neurosis)

The essential feature is a clinical picture in which the predominant disturbance is an unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a serious disease. A thorough physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them, although a coexisting physical disorder may be present. The unrealistic fear or belief of having a disease persists despite medical reassurance and causes impairment in social or occupational functioning. The disturbance is not due to any other mental disorder, such as Schizophrenia, Affective Disorder, or Somatization Disorder.

The preoccupation may be with bodily functions, such as heartbeat, sweating, or peristalsis, or with minor physical abnormalities, such as a small sore or an occasional cough. The individual interprets these sensations or signs as evidence of a serious disease. The feared disease or diseases may involve several body systems at different times or simultaneously. Alternatively, there may be preoccupation with a specific organ and a single disease, as in "cardiac neurosis," in which the individual fears or believes that he or she has heart disease.

Associated features. The medical history is often presented in great detail and at length. A history of "doctor shopping" and deterioration in "doctor-patient" relationships, with frustration and anger on both sides, is common. Individuals with this disorder frequently believe that they are not getting proper care. The physical complaints may be used to exert control over relationships with family and friends.

Anxiety and depressed mood and compulsive personality traits are common.

Age at onset. Most commonly the age at onset is in adolescence, although frequently the disorder begins in the 30s for men and the 40s for women.

Course. The course is usually chronic, with waxing and waning of symptoms.

Impairment. By definition there is always some impairment in social or occupational functioning. Social relations are often strained because the individual is preoccupied with disease. There may be no effect on functioning at work if the individual limits the preoccupation with physical complaints to nonwork time. On the other hand, there may be missed work or interference with work efficiency because of the preoccupation. Impairment is severe when the individual adopts an invalid life-style and becomes bedridden.

Complications. Complications are secondary to efforts to obtain medical care. Because of the multiple physical symptoms without organic basis, true organic pathology may be missed. In addition, when the individual goes from doctor to doctor, there is the danger of repeated diagnostic procedures that carry risks of their own, such as exploratory surgery.

Predisposing factors. A past experience with true organic disease in oneself or a family member and psychosocial stressors apparently predispose to the development of this disorder.

Prevalence. This disorder is commonly seen in general medical practice. Because individuals with the disorder are often offended at the suggestion that their fears or beliefs may be unrealistic, they frequently refuse referral for mental health care and are not often seen in mental health facilities.

Sex ratio. The disorder is equally common in men and women.

Familial pattern. No information.

Differential diagnosis. The most important differential diagnostic consideration is **true organic disease**, such as early stages of neurological disorders (e.g., multiple sclerosis), endocrine disorders (e.g., thyroid or parathyroid disease), and illnesses that frequently affect multiple body systems (e.g., systemic lupus erythematosis). However, the presence of true organic disease does not rule out the possibility of coexisting Hypochondriasis.

In **some psychotic disorders, such as Schizophrenia and Major Depression with Psychotic Features**, there may be somatic delusions of having a disease. In Hypochondriasis the belief of having a disease generally does not have the fixed quality of a true somatic delusion in that usually the individual with Hypochondriasis can entertain the possibility that the feared disease is not present. The symptoms of hypochondriacal preoccupation may be present in psychotic disorders, in which case the additional diagnosis of Hypochondriasis is not made.

In **Dysthymic Disorder, Panic Disorder, Generalized Anxiety Disorder, Obsessive Compulsive Disorder,** and **Somatization Disorder** the symptom of hypochondriacal preoccupation may appear, but generally it is not the predominant disturbance. In Somatization Disorder there tends to be preoccupation with symptoms rather than fear of having a specific disease or diseases. When the criteria for any of these disorders are met and the hypochondriacal preoccupation is due to one of these disorders, the additional diagnosis of Hypochondriasis is not made.

Diagnostic criteria for Hypochondriasis

A. The predominant disturbance is an unrealistic interpretation of physical signs or sensations as abnormal, leading to preoccupation with the fear or belief of having a serious disease.

B. Thorough physical evaluation does not support the diagnosis of any physical disorder that can account for the physical signs or sensations or for the individual's unrealistic interpretation of them.

C. The unrealistic fear or belief of having a disease persists despite medical reassurance and causes impairment in social or occupational functioning.

D. Not due to any other mental disorder such as Schizophrenia, Affective Disorder, or Somatization Disorder.

300.70 Atypical Somatoform Disorder

This is a residual category to be used when the predominant disturbance is the presentation of physical symptoms or complaints not explainable on the basis of demonstrable organic findings or a known pathophysiological mechanism and apparently linked to psychological factors.

An example of cases that can be classified here include those of individuals who are preoccupied with some imagined defect in physical appearance that is out of proportion to any actual physical abnormality that may exist. This syndrome has sometimes been termed "Dysmorphophobia."

Dissociative Disorders

The essential feature is a sudden, temporary alteration in the normally integrative functions of consciousness, identity, or motor behavior. If the alteration occurs in consciousness, important personal events cannot be recalled. If it occurs in identity, either the individual's customary identity is temporarily forgotten and a new identity is assumed, or the customary feeling of one's own reality is lost and replaced by a feeling of unreality. If the alteration occurs in motor behavior, there is also a concurrent disturbance in consciousness or identity, as in the wandering that occurs during a Psychogenic Fugue.

Depersonalization Disorder has been included in the Dissociative Disorders because the feeling of one's own reality, an important component of identity, is lost. Some, however, question this inclusion because disturbance in memory is absent.

Although Sleepwalking Disorder has the essential feature of a Dissociative Disorder, it is classified among the Disorders Usually First Evident in Infancy, Childhood, or Adolescence.

300.12 Psychogenic Amnesia

The essential feature is a sudden inability to recall important personal information, an inability not due to an Organic Mental Disorder. The extent of the disturbance is too great to be explained by ordinary forgetfulness. The diagnosis is not made if the person travels to another locale and assumes a new identity, in which case the diagnosis is Psychogenic Fugue.

There are four types of disturbance in recall. In *localized* (or circumscribed) amnesia, the most common type, there is failure to recall all events occurring during a circumscribed period of time, usually the first few hours following a profoundly disturbing event. For example, the uninjured survivor of a car accident which killed his immediate family cannot recall anything that happened from the time of the accident until two days later. Somewhat less common is *selective* amnesia, a failure to recall some, but not all, of the events occurring during a circumscribed period of time. In the illustration above, the uninjured survivor might recall making the funeral arrangements, but not recall extensive simultaneous discussions with family members. The least common types of disturbance in recall are *generalized* amnesia, in which failure of recall encompasses the individual's entire life, and *continuous* amnesia, in which the individual cannot recall events subsequent to a specific time up to and including the present.

During an ongoing amnestic episode, perplexity, disorientation, and purposeless wandering may occur. When the period of time for which there is amnesia is in the past, the person is usually aware of the disturbance in recall.

Associated features. During the amnestic period there may be indifference toward the memory disturbance. Post-traumatic Stress Disorder may also be present.

Age at onset and sex ratio. Military sources provide many clinical reports describing the disorder in young males during war. The disorder is most often observed in adolescent and young adult females, but rarely in the elderly.

Course and predisposing factors. Amnesia begins suddenly, usually following severe psychosocial stress. The stress often involves a threat of physical injury or death. In other instances the stress is due to the unacceptability of certain impulses or acts, such as an extramarital affair. In still other instances the individual may be in a subjectively intolerable life situation, such as abandonment by a spouse.

Termination of the amnesia is typically abrupt. Recovery is complete and recurrences are rare.

Impairment. The degree of impairment varies from mild to severe in proportion to the duration of the amnestic episode and the importance of forgotten events to the individual's social functioning. The impairment is usually minimal and temporary, since rapid recovery is the rule.

Complications. None.

Prevalence. The condition is apparently rare under normal circumstances; it is more common in wartime or during natural disasters.

Familial pattern. No information.

Differential diagnosis. In **Organic Mental Disorders** there is usually a memory disturbance whose onset has no relationship to stress and that is more marked for recent than for remote events. Memory impairment caused by organic factors usually disappears very slowly, if at all; full return of memory is rare. Furthermore, attention deficits, a clouding of consciousness, and disturbances of affect are frequently present.

In **Substance-induced Intoxication** there can be "blackouts" with failure to recall events that occurred during the intoxication. The organic factor (the substance taken) and the failure to achieve full return of memory clearly distinguish it from Psychogenic Amnesia.

In **Alcohol Amnestic Disorder**, short-term (not immediate) memory is impaired, i.e., events can be recalled immediately after they occur, but not after the passage of a few minutes. This type of memory disturbance is not seen in Psychogenic Amnesia. In addition, blunted affect, confabulation, and lack of awareness of the memory impairment are common in Alcohol Amnestic Disorder.

In **postconcussion amnesia**, the disturbance of recall, though circumscribed,

is often retrograde, encompassing a period of time before the head trauma, whereas in Psychogenic Amnesia the disturbance of recall is almost always anterograde. Retrograde amnesia following head trauma can usually be distinguished from Psychogenic Amnesia by diagnostic use of hypnosis or an amytal interview; prompt recovery of the lost memories suggests a psychogenic basis for the disturbance.

In **epilepsy**, the memory impairment is sudden in onset, motor abnormalities are usually present during the episode, and repeated EEGs typically reveal anomalies.

In **catatonic stupor**, mutism may suggest Psychogenic Amnesia, but failure of recall is nearly always absent, and there usually are other characteristic catatonic symptoms, such as rigidity, posturing, and negativism.

Malingering involving simulated amnesia presents a particularly difficult diagnostic dilemma. Attention to the possibility that the amnesia is feigned plus careful questioning under hypnosis or during an amytal interview should help to resolve the dilemma.

Diagnostic criteria for Psychogenic Amnesia

A. Sudden inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance is not due to an Organic Mental Disorder (e.g., blackouts during Alcohol Intoxication).

300.13 Psychogenic Fugue

The essential feature is sudden, unexpected travel away from home or customary work locale with assumption of a new identity and an inability to recall one's previous identity. Perplexity and disorientation may occur. Following recovery there is no recollection of events that took place during the fugue. The diagnosis is not made in the presence of an Organic Mental Disorder.

In some cases the disorder may be manifested by the assumption of a completely new identity during the fugue, usually marked by more gregarious and uninhibited traits than characterized the former personality, which typically is quiet and altogether ordinary. In such instances the individual may give himself or herself a new name, take up a new residence, and engage in complex social activities that are well-integrated and do not suggest the presence of a mental disorder. In most cases, however, the fugue is less elaborate, and consists of little more than brief, apparently purposeful travel. Social contacts in these cases are minimal or even avoided; the new identity, while present, is incomplete. Occasionally there are outbursts of violence against another person or property. In all cases of fugue, however, the individual's travel and behavior must appear more purposeful than the confused wandering that may be seen in Psychogenic Amnesia.

Associated features. No information.

Age at onset. Variable.

Predisposing factors and course. Heavy alcohol use may predispose to the development of the disorder. Psychogenic Fugue typically follows severe psychosocial stress, such as marital quarrels, personal rejections, military conflict, or natural disaster. Usually the fugue is of brief duration—hours to days—and involves a limited amount of travel; more rarely, it continues for many months and involves complex but unobtrusive travel over thousands of miles and across numerous national borders. Ultimately, rapid recovery occurs; recurrences are rare.

Impairment. The degree of impairment varies with the duration of the fugue and the extent to which it causes subsequent social distress to the individual and his or her associates. When violent behavior has occurred, the social, legal, and other personal sequelae depend on the nature of the violent act. In most cases impairment is minimal and transient.

Complications. None.

Prevalence. Although apparently rare, the disorder is most common in wartime, or in the wake of a natural disaster.

Sex ratio and familial pattern. No information.

Differential diagnosis. Organic Mental Disorders usually involve a disturbance of memory more marked for recent than for remote events; the memory disturbance is not isolated and disappears slowly, if at all; memory rarely is fully restored. Disturbances of attention, clouding of consciousness, and affective disturbances are usually present but unexpected travel is unusual. If travel occurs as part of an Organic Mental Disorder, it is usually not of a complex, purposive, or socially adaptive nature and appears to be mere wandering.

When **temporal lobe epilepsy** involves travel, motoric activity is usually simple rather than complex and there is no assumption of a new identity. Affect is dysphoric. Typically, temporal lobe epilepsy is not precipitated by psychosocial stress.

In **Psychogenic Amnesia**, sudden failure to recall important personal events, including one's personal identity, occurs; but purposeful travel and the assumption of a new identity, partial or complete, are not present.

Malingering, in which there is feigned inability to recall one's previous activity and identity, is exceedingly difficult to distinguish from Psychogenic Fugue. Careful questioning under hypnosis or during an amytal interview can be useful.

Diagnostic criteria for Psychogenic Fugue

A. Sudden unexpected travel away from one's home or customary place of work, with inability to recall one's past.

B. Assumption of a new identity (partial or complete).

C. The disturbance is not due to an Organic Mental Disorder.

300.14 Multiple Personality

The essential feature is the existence within the individual of two or more distinct personalities, each of which is dominant at a particular time. Each personality is a fully integrated and complex unit with unique memories, behavior patterns, and social relationships that determine the nature of the individual's acts when that personality is dominant. Transition from one personality to another is sudden and often associated with psychosocial stress.

Usually the original personality has no knowledge or awareness of the existence of any of the other personalities (subpersonalities). When there are more than two subpersonalities in one individual, each is aware of the others to varying degrees. The subpersonalities may not know each other or be constant companions. At any given moment one personality will interact verbally with the external environment, but none or any number of the other personalities may actively perceive (i.e., "listen in on") all that is going on.

The original personality and all of the subpersonalities are aware of lost periods of time. "They" will usually admit to this if asked, but will seldom volunteer this information.

The individual personalities are nearly always quite discrepant and frequently seem to be opposites. For example, a quiet, retiring spinster may alternate with a flamboyant, promiscuous bar habitué on certain nights. Usually one of the personalities over the course of the disorder is dominant.

Associated features. One or more of the personalities may function with a reasonable degree of adaptation (e.g., be gainfully employed) while alternating with another personality that is clearly maladapted or has a specific, separate, mental disorder. Studies have demonstrated that various subpersonalities in the same individual may have different responses to physiological and psychological measurements.

One or more of the subpersonalities may report being of the opposite sex, of a different race or age, or from a different family than the original personality. Each subpersonality, however, displays behaviors characteristic of its stated age, which is usually younger than the actual age.

One or more of the personalities may be aware of hearing or having heard the voice(s) of one or more of the other personalities or may report having talked with or engaged in activities with one or more of the other personalities. These internal conversations and the belief that one has engaged in activities with another personality when the latter is actually a dissociated aspect of the

original personality must be differentiated from other forms of hallucinatory and delusional experiences.

The subpersonalities often exist in groups of two or three, all of whom represent the same period of life (e.g., adolescence). When this occurs, one or more of these subpersonalities tends to have the role of protector of another member(s) of the group.

Psychosocial stress most often precipitates the transition from one personality to another; hypnosis may also effect this change. Usually transitions occur in a dramatic manner.

Most often, the subpersonalities have proper names, usually different from the first name, and sometimes from both the first and last names, of the original personality. Occasionally one or more subpersonalities are unnamed.

Somatoform Disorders and Psychological Factors Affecting Physical Condition apparently are common in individuals with Multiple Personality.

Age at onset. Onset of Multiple Personality may be in early childhood or later. The disorder is rarely diagnosed until adolescence.

Course. The course tends to be more chronic than in the other Dissociative Disorders.

Impairment. The degree of impairment varies from moderate to severe, depending on the number, nature, and persistence of the various subpersonalities. Impairment is greater than in the other Dissociative Disorders and recovery typically is less complete.

Complications. Transient psychotic episodes, Psychosexual Disorders and Disorders of Impulse Control Not Elsewhere Classified, may be complications.

Predisposing factors. Child abuse and other forms of severe emotional trauma in childhood may be predisposing factors.

Prevalence. The disorder is apparently extremely rare.

Sex ratio. Multiple Personality is most often diagnosed in late adolescent and young adult females.

Familial pattern. No information.

Differential diagnosis. Psychogenic Fugue and **Psychogenic Amnesia** may be confused with Multiple Personality, but do not present its characteristic repeated shifts of identity and usually are limited to a single, brief episode. Also, in both Psychogenic Amnesia and Psychogenic Fugue, awareness of the original personality is absent. Complex social activities, memories, behavior patterns, and friendships are not present in Psychogenic Amnesia and are uncommon in Psychogenic Fugue.

Psychotic disorders such as **Schizophrenic Disorders** may be confused with Multiple Personality because the individual reports hearing or talking with the voices of other personalities.

Malingering can present a difficult diagnostic dilemma. The presence of secondary gain suggests Malingering. Hypnosis or amytal interview may be of help in resolving especially difficult cases.

Diagnostic criteria for Multiple Personality

A. The existence within the individual of two or more distinct personalities, each of which is dominant at a particular time.

B. The personality that is dominant at any particular time determines the individual's behavior.

C. Each individual personality is complex and integrated with its own unique behavior patterns and social relationships.

300.60 Depersonalization Disorder

The essential feature is the occurrence of one or more episodes of depersonalization that cause social or occupational impairment. The diagnosis is not made when the symptom of depersonalization is secondary to any other disorder. (Mild depersonalization, without significant impairment, is estimated to occur at some time in 30%-70% of young adults.)

The symptom of depersonalization involves an alteration in the perception or experience of the self so that the usual sense of one's own reality is temporarily lost or changed. This is manifested by a sensation of self-estrangement or unreality, which may include the feeling that one's extremities have changed in size, or the experience of seeming to perceive oneself from a distance. In addition, the individual may feel "mechanical" or as though in a dream. Various types of sensory anesthesias and a feeling of not being in complete control of one's actions, including speech, are often present. All of these feelings are egodystonic, and the individual maintains grossly intact reality testing.

The onset of depersonalization is rapid; its disappearance is more gradual.

Associated features. Derealization is frequently present. This is manifested by a strange alteration in the perception of one's surroundings so that a sense of the reality of the external world is lost. A perceived change in the size or shape of objects in the external world is common. People may be perceived as dead or mechanical.

Other common associated features include dizziness, depression, obsessive ruminations, anxiety, fear of going insane, and a disturbance in the subjective sense of time. There is often the feeling that recall is difficult or slow.

Age at onset. The disorder usually begins in adolescence. Onset after the age of forty is extremely rare.

Course. The course is generally chronic and marked by remissions and exacerbations. Most often the exacerbations occur when there is mild anxiety or depression.

Impairment. The degree of impairment is usually minimal, but may be exacerbated by the presence of associated features such as anxiety or fear of insanity.

Complications. Hypochondriasis may be a complication of this disorder.

Predisposing factors. Fatigue, recovery from Substance Intoxication, hypnosis, meditation, physical pain, anxiety, depression, and severe stress, such as military combat or an auto accident, predispose to episodes of Depersonalization Disorder.

Prevalence, familial pattern, and sex ratio. No information.

Differential diagnosis. The **symptom of depersonalization**, even if recurrent, that does not cause any social or occupational impairment, must be distinguished from Depersonalization Disorder.

In **Schizophrenia, Affective Disorders, Organic Mental Disorders** (especially **Intoxication** or **Withdrawal**), **Anxiety Disorders, Personality Disorders,** and **epilepsy,** depersonalization may be a symptom. In such cases, the additional diagnosis of Depersonalization Disorder is not made.

Diagnostic criteria for Depersonalization Disorder

A. One or more episodes of depersonalization sufficient to produce significant impairment in social or occupational functioning.

B. The symptom is not due to any other disorder, such as Schizophrenia, Affective Disorder, Organic Mental Disorder, Anxiety Disorder, or epilepsy.

300.15 Atypical Dissociative Disorder

This is a residual category to be used for individuals who appear to have a Dissociative Disorder but do not satisfy the criteria for a specific Dissociative Disorder. Examples include trance-like states, derealization unaccompanied by depersonalization, and those more prolonged dissociated states that may occur in persons who have been subjected to periods of prolonged and intense coercive persuasion (brainwashing, thought reform, and indoctrination while the captive of terrorists or cultists).

Psychosexual Disorders

The name for this diagnostic class emphasizes that psychological factors are assumed to be of major etiological significance in the development of the disorders listed here. Disorders of sexual functioning that are caused exclusively by organic factors, even though they may have psychological consequences, are not listed in this classification. For example, impotence due to spinal-cord injury is coded on Axis III as a physical disorder, and the psychological reaction to that condition could be coded as an Adjustment Disorder, or some other suitable category, on Axis I.

The Psychosexual Disorders are divided into four groups. The Gender Identity Disorders are characterized by the individual's feelings of discomfort and inappropriateness about his or her anatomic sex and by persistent behaviors generally associated with the other sex. The Paraphilias are characterized by arousal in response to sexual objects or situations that are not part of normative arousal-activity patterns and that in varying degrees may interfere with the capacity for reciprocal affectionate sexual activity. The Psychosexual Dysfunctions are characterized by inhibitions in sexual desire or the psychophysiological changes that characterize the sexual response cycle. Finally, there is a residual class of Other Psychosexual Disorders that has two categories: Ego-dystonic Homosexuality and a final residual category, Psychosexual Disorders Not Elsewhere Classified.

GENDER IDENTITY DISORDERS

The essential feature of the disorders included in this subclass is an incongruence between anatomic sex and gender identity. Gender identity is the sense of knowing to which sex one belongs, that is, the awareness that "I am a male," or "I am a female." Gender identity is the private experience of gender role, and gender role is the public expression of gender identity. Gender role can be defined as everything that one says and does, including sexual arousal, to indicate to others or to the self the degree to which one is male or female.

Disturbance in gender identity is rare, and should not be confused with the far more common phenomena of feelings of inadequacy in fulfilling the expectations associated with one's gender role. An example would be an individual who perceives himself or herself as being sexually unattractive yet experiences himself or herself unambiguously as a man or woman in accordance with his or her anatomic sex.

302.5x Transsexualism

The essential features of this heterogeneous disorder are a persistent sense of discomfort and inappropriateness about one's anatomic sex and a persistent wish

to be rid of one's genitals and to live as a member of the other sex. The diagnosis is made only if the disturbance has been continuous (not limited to periods of stress) for at least two years, is not due to another mental disorder, such as Schizophrenia, and is not associated with physical intersex or genetic abnormality.

Individuals with this disorder usually complain that they are uncomfortable wearing the clothes of their own anatomic sex; frequently this discomfort leads to cross-dressing (dressing in clothes of the other sex). Often they choose to engage in activities that in our culture tend to be associated with the other sex. These individuals often find their genitals repugnant, which may lead to persistent requests for sex reassignment by surgical or hormonal means.

To varying degrees, the behavior, dress, and mannerisms are those of the other sex. With cross-dressing, hormonal treatment, and electrolysis, a few males with the disorder will appear relatively indistinguishable from members of the other sex. However, the anatomic sex of most males and females with the disorder is quite apparent to the alert observer.

Associated features. Generally there is moderate to severe coexisting personality disturbance. Frequently there is considerable anxiety and depression, which the individual may attribute to inability to live in the role of the desired sex.

Course and subtypes. The disorder is subdivided according to the predominant prior sexual history, which is coded in the fifth digit as 1 = asexual, 2 = homosexual (same anatomic sex), 3 = heterosexual (opposite anatomic sex), and 0 = unspecified. In the first, "asexual," the individual reports never having had strong sexual feelings. Often there is the additional history of little or no sexual activity or pleasure derived from the genitals. In the second group, "homosexual," a predominantly homosexual (object choice is same anatomic sex) arousal pattern preceding the onset of the Transsexualism is acknowledged, although often such individuals will deny that the behavior is homosexual because of their conviction that they are "really" of the other sex. In the third group, "heterosexual," the individual claims to have had an active heterosexual life.

Without treatment, the course of all three types is chronic and unremitting. Since surgical sex reassignment is a recent development, the long-term course of the disorder with this treatment is unknown.

Individuals who have female-to-male Transsexualism appear to represent a more homogeneous group than those who have male-to-female Transsexualism in that they are more likely to have a history of homosexuality and to have a more stable course, with or without treatment.

Age at onset. Individuals who develop Transsexualism often evidenced gender identity problems as children. However, some assert that although they were secretly aware of their gender problem, it was not evident to their family and friends. The age at which the full syndrome appears for those with the "asexual" or "homosexual" course is most often in late adolescence or early

adult life. In individuals with the "heterosexual" course, the disorder may have a later onset.

Impairment and complications. Frequently social and occupational functioning are markedly impaired, partly because of associated psychopathology and partly because of problems encountered in attempting to live in the desired gender role. Depression is common, and can lead to suicide attempts. In rare instances males may mutilate their genitals.

Predisposing factors. Extensive, pervasive, childhood femininity in a boy or childhood masculinity in a girl increases the likelihood of Transsexualism. Transsexualism seems always to develop in the context of a disturbed parent-child relationship. Some cases of Transvestism evolve into Transsexualism.

Prevalence. The disorder is apparently rare.

Sex ratio. Males are more common than females among people who seek help at clinics specializing in the treatment of this disorder. The ratio varies from as high as 8:1 to as low as 2:1.

Familial pattern. No information.

Differential diagnosis. In **effeminate homosexuality** the individual displays behaviors characteristic of the opposite sex. However, such individuals have no desire to be of the other anatomic sex. In **physical intersex** the individual may have a disturbance in gender identity. However, the presence of abnormal sexual structures rules out the diagnosis of Transsexualism.

Other individuals with a disturbed gender identity may, in isolated periods of stress, wish to belong to the other sex and to be rid of their own genitals. In such cases the diagnosis Atypical Gender Identity Disorder should be considered, since the diagnosis of Transsexualism is made only when the disturbance has been continuous for at least two years. In **Schizophrenia,** there may be delusions of belonging to the other sex, but this is rare. The insistence by an individual with Transsexualism that he or she is of the other sex is, strictly speaking, not a delusion since what is invariably meant is that the individual *feels like* a member of the other sex rather than a true belief that he or she *is* a member of the other sex.

In both **Transvestism** and **Transsexualism** there may be cross-dressing. However, in Transvestism that has not evolved into Transsexualism there is no wish to be rid of one's own genitals.

Diagnostic criteria for Transsexualism

A. Sense of discomfort and inappropriateness about one's anatomic sex.

B. Wish to be rid of one's own genitals and to live as a member of the other sex.

C. The disturbance has been continuous (not limited to periods of stress) for at least two years.

D. Absence of physical intersex or genetic abnormality.

E. Not due to another mental disorder, such as Schizophrenia.

Fifth-digit code numbers and subclassification. The predominant prior sexual history is recorded in the fifth digit as:

1 = asexual
2 = homosexual (same anatomic sex)
3 = heterosexual (other anatomic sex)
0 = unspecified

302.60 Gender Identity Disorder of Childhood

The essential features are a persistent feeling of discomfort and inappropriateness in a child about his or her anatomic sex and the desire to be, or insistence that he or she is, of the other sex. In addition, there is a persistent repudiation of the individual's own anatomic attributes. This is not merely the rejection of stereotypical sex role behavior as, for example, in "tomboyishness" in girls or "sissyish'" behavior in boys, but rather a profound disturbance of the normal sense of maleness or femaleness.

Girls with this disorder regularly have male peer groups, an avid interest in sports and rough-and-tumble play, and a lack of interest in playing with dolls or playing "house" (unless playing the father or another male role). More rarely, a girl with this disorder claims that she will grow up to become a man (not merely in role), that she is biologically unable to become pregnant, that she will not develop breasts, or that she has, or will grow, a penis.

Boys with this disorder invariably are preoccupied with female stereotypical activities. They may have a preference for dressing in girls' or women's clothes, or may improvise such items from available material when genuine articles are unavailable. (The cross-dressing never causes sexual excitement.) They often have a compelling desire to participate in the games and pastimes of girls. Dolls are often the favorite toy, and girls are regularly the preferred playmates. When playing "house," the role of a female is typically adopted. Rough-and-tumble play or sports are regularly avoided. Gestures and actions are often judged against a standard of cultural stereotype to be feminine, and the boy is invariably subjected to male peer group teasing and rejection, which rarely occurs among girls until adolescence. In rare cases a boy with this disorder claims that his penis or testes are disgusting or will disappear, or that it would be better not to have a penis or testes.

Some children refuse to attend school because of teasing or pressure to dress in attire stereotypical of their sex. Most children with this disorder deny being disturbed by it except as it brings them into conflict with the expectations of their family or peers.

Associated features. Some of these children, particularly girls, show no

other signs of psychopathology. Others may display serious signs of disturbance, such as phobias and persistent nightmares.

Age at onset and course. Three-fourths of the boys who cross-dress begin to do so before their fourth birthday; playing with dolls begins during the same period. Social ostracism increases during the early grades of school, and social conflict is significant at about age seven or eight. During the later grade-school years, grossly feminine behavior may lessen. An as yet undetermined proportion of boys, perhaps one-third to one-half, become aware of a homosexual orientation during adolescence.

For females the age at onset is also early, but most begin to acquiesce to social pressure during late childhood or adolescence and give up an exaggerated insistence on male activities and attire. A minority retain a masculine identification and some of these develop a homosexual arousal pattern.

Complications. In a small number of cases, the disorder becomes continuous with Transsexualism.

Impairment. Peer relations with members of the same sex are absent or difficult to establish. The amount of impairment varies from none to extreme, and is related to the degree of underlying psychopathology and the reaction of peers and family to the individual's behavior.

Prevalence. The disorder is apparently rare.

Sex ratio and familial pattern. No information.

Predisposing factors. Extreme, excessive, and prolonged physical and emotional closeness between the infant and the mother and a relative absence of the father during the earliest years may contribute to the development of this disorder in the male. Females who later develop this disorder have mothers who were apparently unavailable to them at a very early age, either psychologically or physically, because of illness or abandonment; the girl seems to make a compensatory identification with the father, which leads to the adoption of a male gender identity.

Differential diagnosis. Children whose behavior merely does not fit the cultural stereotype of masculinity or femininity should not be given this diagnosis unless the full syndrome is present. **Physical abnormalities of the sex organs** are rarely associated with Gender Identity Disorder; when they are present, the physical disorder should be noted on Axis III.

Diagnostic criteria for Gender Identity Disorder of Childhood

For females:

A. Strongly and persistently stated desire to be a boy, or insistence that she is a boy (not merely a desire for any perceived cultural advantages from being a boy).

B. Persistent repudiation of female anatomic structures, as manifested by at least one of the following repeated assertions:

(1) that she will grow up to become a man (not merely in role)
(2) that she is biologically unable to become pregnant
(3) that she will not develop breasts
(4) that she has no vagina
(5) that she has, or will grow, a penis

C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)

For males:

A. Strongly and persistently stated desire to be a girl, or insistence that he is a girl.

B. Either (1) or (2):

(1) persistent repudiation of male anatomic structures, as manifested by at least one of the following repeated assertions:

(a) that he will grow up to become a woman (not merely in role)
(*b*) that his penis or testes are disgusting or will disappear
(*c*) that it would be better not to have a penis or testes

(2) preoccupation with female stereotypical activities as manifested by a preference for either cross-dressing or simulating female attire, or by a compelling desire to participate in the games and pastimes of girls

C. Onset of the disturbance before puberty. (For adults and adolescents, see Atypical Gender Identity Disorder.)

302.85 Atypical Gender Identity Disorder

This is a residual category for coding disorders in gender identity that are not classifiable as a specific Gender Identity Disorder.

PARAPHILIAS

The essential feature of disorders in this subclass is that unusual or bizarre imagery or acts are necessary for sexual excitement. Such imagery or acts tend to be insistently and involuntarily repetitive and generally involve either: (1) preference for use of a nonhuman object for sexual arousal, (2) repetitive sexual activity with humans involving real or simulated suffering or humiliation, or (3) repetitive sexual activity with nonconsenting partners. In other classifications these disorders are referred to as Sexual Deviations. The term Paraphilia is

preferable because it correctly emphasizes that the deviation (para) is in that to which the individual is attracted (philia).

The imagery in a Paraphilia, such as simulated bondage, may be playful and harmless and acted out with a mutually consenting partner. More likely it is not reciprocated by the partner, who consequently feels erotically excluded or superfluous to some degree. In more extreme form, paraphiliac imagery is acted out with a nonconsenting partner, and is noxious and injurious to the partner (as in severe Sexual Sadism) or to the self (as in Sexual Masochism).

Since paraphiliac imagery is necessary for erotic arousal, it must be included in masturbatory or coital fantasies, if not actually acted out alone or with a partner and supporting cast or paraphernalia. In the absence of paraphiliac imagery there is no relief from nonerotic tension, and sexual excitement or orgasm is not attained.

The imagery in a paraphiliac fantasy or the object of sexual excitement in a Paraphilia is frequently the stimulus for sexual excitement in individuals without a Psychosexual Disorder. For example, women's undergarments and imagery of sexual coercion are sexually exciting for many men; they are paraphiliac only when they become necessary for sexual excitement.

The Paraphilias included here are, by and large, conditions that traditionally have been specifically identified by previous classifications. Some of them are extremely rare; others are relatively common. Because some of these disorders are associated with nonconsenting partners, they are of legal and social significance. Individuals with these disorders tend not to regard themselves as ill, and usually come to the attention of mental health professionals only when their behavior has brought them into conflict with society.

The specific Paraphilias described here are: (1) Fetishism, (2) Transvestism, (3) Zoophilia, (4) Pedophilia, (5) Exhibitionism, (6) Voyeurism, (7) Sexual Masochism, and (8) Sexual Sadism. Finally, there is a residual category, Atypical Paraphilia, for noting the many other Paraphilias that exist but that have not been sufficiently described to date to warrant inclusion as specific categories.

Paraphilias may be multiple or may coexist with other mental disorders, such as Schizophrenia or various Personality Disorders. In such cases multiple diagnoses should be made.

Associated features. Frequently these individuals assert that the behavior causes them no distress and that their only problem is the reaction of others to their behavior. Others admit to guilt, shame, and depression at having to engage in an unusual sexual activity that is socially unacceptable. There is often impairment in the capacity for reciprocal affectionate sexual activity, and psychosexual dysfunctions are common. Personality disturbances, particularly emotional immaturity, are also frequent.

Impairment. Social and sexual relationships may suffer if others, such as a spouse (many of these individuals are married), become aware of the unusual sexual behavior. In addition, if the individual engages in sexual activity with a partner who refuses to cooperate in the unusual behavior, such as fetishistic or sadistic behavior, sexual excitement may be inhibited and the relationship may

suffer. In rare instances the unusual behavior may become the major activity in the individual's life, such as the collection of fetishes or voyeuristic acts.

Complications. In Zoophilia physical harm may result from sexual activity with animals. In Sexual Masochism, the individual may inflict serious physical damage on himself or herself. Paraphilias involving another person, particularly Voyeurism, Exhibitionism, and Pedophilia, often lead to arrest and incarceration. Sexual offenses against children constitute a significant proportion of all reported criminal sex acts. Individuals with Exhibitionism make up about one-third of all apprehended sex offenders.

Predisposing factors. With the exception of Transvestism (see p. 269), predisposing factors are unknown.

Prevalence. The disorders are apparently rare.

Sex ratio. Virtually all reported cases have been in males, with the exception of Sexual Sadism and Sexual Masochism, which, however, occur far more commonly in males. Although no cases of Voyeurism in women have been reported in the literature, some clinicians claim to know of such cases.

Familial pattern. No information.

302.81 Fetishism

The essential feature is the use of nonliving objects (fetishes) as a repeatedly preferred or exclusive method of achieving sexual excitement. The diagnosis is not made when the fetishes are limited to articles of female clothing used in cross-dressing, as in Transvestism, or when the object is sexually stimulating because it has been designed for that purpose, e.g., a vibrator.

Sexual activity may involve the fetish alone, such as masturbation into a shoe, or the fetish may be integrated into sexual activities with a human partner. In the latter situation the fetish is required or strongly preferred for sexual excitement, and in its absence there may be erectile failure in males.

Fetishes tend to be articles of clothing, such as female undergarments, shoes, and boots, or, more rarely, parts of the human body, such as hair or nails. The fetish is often associated with someone with whom the individual was intimately involved during childhood, most often a caretaker.

Age at onset. Usually the disorder begins by adolescence, although the fetish may have been endowed with special significance earlier, in childhood. Once established, the disorder tends to be chronic.

Differential diagnosis. Nonpathological sexual experimentation can involve sexual arousal by nonhuman objects, but this stimulus for sexual excitement is neither persistently preferred nor required.

In **Transvestism** the sexual arousal is limited to articles of female clothing used in cross-dressing. Although Transvestism could be considered fetishistic cross-dressing, the additional diagnosis of Fetishism should not be made.

Diagnostic criteria for Fetishism

A. The use of nonliving objects (fetishes) is a repeatedly preferred or exclusive method of achieving sexual excitement.

B. The fetishes are not limited to articles of female clothing used in cross-dressing (Transvestism) or to objects designed to be used for the purpose of sexual stimulation (e.g., vibrator).

302.30 Transvestism

The essential feature is recurrent and persistent cross-dressing by a heterosexual male that during at least the initial phase of the illness is for the purpose of sexual excitement. Interference with the cross-dressing results in intense frustration. This diagnosis is not made in those rare instances in which the disturbance has evolved into Transsexualism.

Transvestic phenomena range from occasional solitary wearing of female clothes to extensive involvement in a transvestic subculture. Usually more than one article of women's clothing is involved, and the man may dress entirely as a woman. The degree to which the cross-dressed individual appears as a woman varies, depending on mannerisms, body habitus, and cross-dressing skill. When not cross-dressed, he is usually unremarkably masculine. Although the basic preference is heterosexual, rarely has the individual had sexual experience with several women, and occasional homosexual acts may occur.

Age at onset and course. Cross-dressing typically begins in childhood or early adolescence. In some cases the cross-dressing is not done in public until adulthood. The initial experience may involve partial or total cross-dressing; when it is partial, it often progresses to total. A favored article of clothing may become erotic in itself and may habitually be used first in masturbation, and later in intercourse. In some individuals sexual arousal by the clothing tends to disappear, although the cross-dressing continues as an antidote to anxiety. Cross-dressing, although intermittent in the beginning, often becomes more frequent, and may become habitual. A small number of individuals with Transvestism, as the years pass, want to dress and live permanently as women, and the disorder may evolve into Transsexualism.

Predisposing factors. According to the folklore of individuals with this condition, a "petticoat punishment," the punishment of humiliating a boy by dressing him in the clothes of a girl, is common in the history of individuals who later develop this disorder.

Differential diagnosis. In **Transsexualism** there is a persistent wish to be rid of one's own genitals and to live as a member of the other sex, and there is never any sexual excitement with cross-dressing. The individual with Transvestism considers himself to be basically male, whereas the anatomically male Transsexual has a female sexual identity. In those rare instances when Transvestism evolves into Transsexualism, the diagnosis of Transvestism is changed to Transsexualism.

Cross-dressing for the relief of tension or gender discomfort may be done without directly causing sexual excitement. This should not be diagnosed as Transvestism; the diagnosis of Atypical Gender Identity Disorder should be considered. **In male homosexuality** there may be occasional cross-dressing to attract another male or to masquerade in theatrical fashion as a woman. However, the act of cross-dressing does not cause sexual arousal. **In female impersonators,** unless Transvestism is also present, the act of cross-dressing does not cause sexual arousal, and interference with the cross-dressing does not result in intense frustration.

Fetishism is not diagnosed when sexual arousal by nonhuman objects is limited to articles of female clothing used in cross-dressing.

Diagnostic criteria for Transvestism

A. Recurrent and persistent cross-dressing by a heterosexual male.

B. Use of cross-dressing for the purpose of sexual excitement, at least initially in the course of the disorder.

C. Intense frustration when the cross-dressing is interfered with.

D. Does not meet the criteria for Transsexualism.

302.10 Zoophilia

The essential feature is the use of animals as a repeatedly preferred or exclusive method of achieving sexual excitement. The animal may be the object of intercourse or may be trained to sexually excite the human partner by licking or rubbing. Usually the preferred animal is one with which the individual had contact during childhood, such as a household pet or farm animal. The animal is preferred no matter what other forms of sexual outlet are available.

Age at onset. No information.

Course. Initially in the course of the disorder there may also be sexual arousal by humans. As time progresses, however, the animal becomes the most powerful sexual stimulus. This usually occurs by early adulthood and the course then becomes chronic.

Differential diagnosis. Nonpathological sexual activity with animals may occur because of the unavailability of suitable human partners or as a form of sexual experimentation. In such instances the use of animals is not the consistently preferred method of achieving sexual excitement.

Diagnostic criteria for Zoophilia

The act or fantasy of engaging in sexual activity with animals is a repeatedly preferred or exclusive method of achieving sexual excitement.

302.20 Pedophilia

The essential feature is the act or fantasy of engaging in sexual activity with prepubertal children as a repeatedly preferred or exclusive method of achieving sexual excitement. The difference in age between the adult with this disorder and the prepubertal child is arbitrarily set at ten years or more. For late adolescents with the disorder, no precise age difference is specified; and clinical judgment must be used, the sexual maturity of the child as well as the age difference being taken into account.

Adults with the disorder are oriented toward children of the other sex twice as often as toward children of the same sex. The sexual behavior of these two groups is different. Heterosexually oriented males tend to prefer eight-to-ten year-old girls, the desired sexual activity usually being limited to looking or touching. Most incidents are initiated by adults who are in the intimate interpersonal environment of the child. Homosexually oriented males tend to prefer slightly older children. The percentage of couples in this group who know each other only casually is higher than in the heterosexually oriented group. Individuals with undifferentiated sexual object preference tend to prefer younger children than either of the other two groups.

Most individuals oriented homosexually have not been married, whereas most individuals oriented heterosexually either have been or are married.

Age at onset. The disorder may begin at any time in adulthood; most frequently it begins in middle age.

Course. The course is unknown, although homosexually oriented Pedophilia tends to be chronic. The severity of the condition often fluctuates with psychosocial stress. The recidivism rate for homosexually oriented Pedophilia is second only to that for Exhibitionism, and ranges from 13% to 28% of those apprehended, roughly twice that of heterosexually oriented Pedophilia.

Differential diagnosis. Isolated sexual acts with children do not warrant the diagnosis of Pedophilia. Such acts may be precipitated by marital discord, recent loss, or intense loneliness. In such instances the desire for sex with a child may be understood as a substitute for a preferred but unavailable adult. In **Mental Retardation, Organic Personality Syndrome, Alcohol Intoxication,** or **Schizophrenia** there may be a decrease in impulse control, particularly in the elderly, that in rare instances leads to isolated sexual acts with children. However, sexual activity with children is generally not the consistently preferred method for achieving sexual excitement.

In **Exhibitionism** exposure may be to a child, but the act is not a prelude to further sexual activity with the child.

Sexual Sadism may, in extremely rare instances, be associated with Pedophilia, in which case both diagnoses are warranted.

Diagnostic criteria for Pedophilia

A. The act or fantasy of engaging in sexual activity with prepubertal chil-

dren is a repeatedly preferred or exclusive method of achieving sexual excitement.

B. If the individual is an adult, the prepubertal children are at least ten years younger than the individual. If the individual is a late adolescent, no precise age difference is required, and clinical judgment must take into account the age difference as well as the sexual maturity of the child.

302.40 Exhibitionism

The essential feature is repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger. The wish to surprise or shock the observer is often consciously perceived or close to conscious awareness, but these individuals are usually not physically dangerous to the victim. Sometimes the individual masturbates while exposing himself. The condition apparently occurs only in males, and the victims are female children or adults.

Age at onset and course. The disorder may first occur at any time from preadolescence to middle age, although it rarely begins at either end of the age spectrum. The peak age at onset is the middle 20s, with a smaller peak in mid-puberty.

Few arrests are made in the older age groups, which suggests that the condition becomes less severe after age 40.

Differential diagnosis. Repeated exposure without experiencing sexual excitement from the act is engaged in by a small number of individuals. They should not receive the diagnosis of Exhibitionism since it is likely that such individuals suffer from another disorder.

When exposure occurs in **Pedophilia** it is a prelude to sexual activity with the child.

Diagnostic criteria for Exhibitionism

Repetitive acts of exposing the genitals to an unsuspecting stranger for the purpose of achieving sexual excitement, with no attempt at further sexual activity with the stranger.

302.82 Voyeurism

The essential feature is repetitive looking at unsuspecting people, usually strangers, who are either naked, in the act of disrobing, or engaging in sexual activity, as the repeatedly preferred or exclusive method of achieving sexual excitement. The act of looking ("peeping") is for the purpose of achieving sexual excitement, and no sexual activity with the person is sought. Orgasm, usually produced by masturbation, may occur during the voyeuristic activity, or later in response to the memory of what the individual has witnessed. Often these individuals enjoy thinking about the observed individuals' being helpless and feeling humiliated if

they knew they were being seen. In its severe form, peeping constitutes the exclusive form of sexual activity.

Age at onset. The first voyeuristic act is likely to occur in early adulthood.

Course. The course tends to be chronic.

Differential diagnosis. Normal sexual activity often includes sexual excitement from observing nudity, undressing, or sexual activity. However, it is not with an unsuspecting partner, and it is usually a prelude to further sexual activity. **Watching pornography,** filmed or live, causes sexual excitement. However, the people who are being observed are willingly in view, even though in fantasy the observer may *imagine* (but knows better) that the people are unsuspecting.

Diagnostic criteria for Voyeurism

A. The individual repeatedly observes unsuspecting people who are naked, in the act of disrobing, or engaging in sexual activity and no sexual activity with the observed people is sought.

B. The observing is the repeatedly preferred or exclusive method of achieving sexual excitement.

302.83 Sexual Masochism

The essential feature is sexual excitement produced in an individual by his or her own suffering. The diagnosis of Sexual Masochism is warranted under either of two conditions:

(1) A preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer.
(2) The individual has intentionally participated in an activity in which he or she was physically harmed or his or her life was threatened in order to produce sexual excitement, which did occur. A single well-documented episode is sufficient to make the diagnosis.

Age at onset. Masochistic sexual fantasies are likely to have been present in childhood. However, the age when masochistic activities with partners first begin is variable, but is commonly by early adulthood.

Course. The disorder is usually chronic. Self-mutilation, if engaged in, is likely to be repeated. Some individuals with the disorder may for many years engage in masochistic acts without a need to increase the potential for self-harm. Others, however, either because of an increased need or a diminished capacity for restraint, increase the severity of the masochistic acts over time, or during periods of stress, which may result in death.

Differential diagnosis. Masochistic fantasies of being bound, beaten, raped,

or otherwise humiliated may facilitate sexual excitement in some individuals; without such fantasies, they find sexual arousal inadequate. The diagnosis of Sexual Masochism is made only if the individual engages in masochistic sexual acts, not merely fantasies. (If the need for masochistic fantasies is considered clinically significant, it may be diagnosed as Psychosexual Disorder Not Elsewhere Classified.) Some individuals have experimented with bondage or have occasionally experienced erotic excitement as a result of unintentionally having been humiliated, but these situations are also not sufficient for diagnosing this disorder. **Masochistic personality traits,** such as the need to be disappointed or humiliated, are distinguished from Sexual Masochism by the fact that they are not associated with sexual excitement.

Diagnostic criteria for Sexual Masochism
Either (1) or (2):

(1) a preferred or exclusive mode of producing sexual excitement is to be humiliated, bound, beaten, or otherwise made to suffer

(2) the individual has intentionally participated in an activity in which he or she was physically harmed or his or her life was threatened, in order to produce sexual excitement

302.84 Sexual Sadism

The essential feature is the infliction of physical or psychological suffering on another person in order to achieve sexual excitement.

The diagnosis of Sexual Sadism is warranted under any of three different conditions:

(1) On a nonconsenting partner, the individual has repeatedly and intentionally inflicted psychological or physical suffering in order to achieve sexual excitement.

(2) With a consenting partner a repeatedly preferred or exclusive mode of achieving sexual excitement combines humiliation with simulated or mildly injurious bodily suffering.

(3) On a consenting partner bodily injury that is extensive, permanent, or possibly mortal is inflicted in order to achieve sexual excitement.

Age at onset. Sadistic sexual fantasies are likely to have been present in childhood. The age at onset of sadistic activities is also variable, but is commonly by early adulthood.

Course. The condition is usually chronic in its extreme form. When Sexual Sadism is practiced with nonconsenting partners, the activity is likely to be repeated until the individual is apprehended.

Some individuals with the disorder may for many years engage in sadistic acts without a need to increase the potential for inflicting serious physical damage. Others, however, either because of an increased need or a diminished capacity for restraint, increase the severity of the sadistic acts over time or during

periods of stress. When the disorder is severe, these individuals may rape, torture, or kill their victims.

Familial pattern. Although brutality commonly occurs in the families of individuals with this disorder, there is no information on whether Sexual Sadism is more common in family members.

Differential diagnosis. Rape or other sexual assault may be committed by individuals with this disorder. In such instances the suffering inflicted on the victim increases the sexual excitement of the assailant. However, it should not be assumed that all or even many rapists are motivated by Sexual Sadism. Often a rapist is not motivated by the prospect of inflicting suffering, and may even lose sexual desire as a consequence. These represent two ends of a spectrum, and for cases falling in the middle, it may be very difficult for the clinician to decide if the diagnosis of Sexual Sadism is warranted.

Diagnostic criteria for Sexual Sadism
One of the following:

(1) on a nonconsenting partner, the individual has repeatedly intentionally inflicted psychological or physical suffering in order to produce sexual excitement
(2) with a consenting partner, the repeatedly preferred or exclusive mode of achieving sexual excitement combines humiliation with simulated or mildly injurious bodily suffering
(3) on a consenting partner, bodily injury that is extensive, permanent, or possibly mortal is inflicted in order to achieve sexual excitement

302.90 Atypical Paraphilia
This is a residual category for individuals with Paraphilias that cannot be classified in any of the other categories. Such conditions include: Coprophilia (feces); Frotteurism (rubbing); Klismaphilia (enema); Mysophilia (filth); Necrophilia (corpse); Telephone Scatologia (lewdness); and Urophilia (urine).

PSYCHOSEXUAL DYSFUNCTIONS

The essential feature is inhibition in the appetitive or psychophysiological changes that characterize the complete sexual response cycle. Ordinarily this diagnostic category will be applied only when the disturbance is a major part of the clinical picture, although it may not be part of the chief complaint. The diagnosis is not made if the sexual dysfunction is attributed entirely to organic factors, such as a physical disorder or a medication, or if it is due to another Axis I mental disorder.

The complete sexual response cycle can be divided into the following phases:

1. *Appetitive.* This consists of fantasies about sexual activity and a desire to have sexual activity.

2. *Excitement.* This consists of a subjective sense of sexual pleasure and accompanying physiological changes. The major change in the male consists of penile tumescence leading to erection. In addition, there is the appearance of Cowper's gland secretion. The major changes in the female consist of vasocongestion generalized in the pelvis with vaginal lubrication and swelling of the external genitalia. In addition there are the development of the orgasmic platform, which is the narrowing of the outer third of the vagina by increased pubococcygeal muscle tension and vasocongestion; vasocongestion of the labia minora; breast tumescence; and lengthening and widening of the inner two-thirds of the vagina.

3. *Orgasm.* This consists of a peaking of sexual pleasure, with release of sexual tension and rhythmic contraction of the perineal muscles and pelvic reproductive organs. In the male there is the sensation of ejaculatory inevitability, which is followed by emission of semen, caused by contractions of the prostate, seminal vesicles, and urethra. In the female there are contractions, not always subjectively experienced as such, of the wall of the outer third of the vagina. In both the male and the female there is often generalized muscular tension or contractions, such as involuntary pelvic thrusting.

4. *Resolution.* This consists of a sense of general relaxation, well-being, and muscular relaxation. During this phase men are physiologically refractory to further erection and orgasm for a period of time. In contrast, women may be able to respond to additional stimulation almost immediately.

Inhibitions in the response cycle may occur at one or more of these phases, although inhibition in the resolution phase is rarely of primary clinical significance. Whenever more than one Psychosexual Dysfunction is present, they should all be recorded, in the order of clinical significance.

The particular manifestations of each of the Psychosexual Dysfunctions are noted in the diagnostic criteria. In most instances there will be a disturbance in both the subjective sense of pleasure or desire and objective performance. More rarely there may be subjective disturbance alone, without any objective signs of dysfunction, or, conversely, inhibition in performance without any acknowledged subjective distress.

In specifying diagnostic criteria, no attempt is made to require a minimum proportion or type of sexual encounter in which the dysfunction must occur to warrant a diagnosis. This judgment has to be made by the clinician, who must take into account various factors such as frequency, chronicity, subjective distress, and effect on other areas of functioning. The phrase "recurrent and persistent" in the diagnostic criteria is a shorthand method of designating the need for such a clinical judgment.

All of the dysfunctions may be lifelong or acquired (developing after a period of normal functioning), generalized or situational (limited to certain situations or with certain partners), and total or partial (degree or frequency of dis-

turbance). Although in most instances the dysfunctions occur during sexual activity with a partner, in some cases it may be appropriate to identify dysfunctions that occur during masturbation.

Associated features. Frequently there are no other obvious signs of disturbance. This is particularly the case in Inhibited Sexual Desire, since it does not necessarily involve impairment in performance. In other cases there may be a vague sense of not living up to some ill-defined concept of normality, or there may be a variety of complaints, such as depression, anxiety, guilt, shame, frustration, and somatic symptoms. Almost invariably a fear of failure and the development of a "spectator" attitude (self-monitoring), with extreme sensitivity to the reaction of the sexual partner, are present. This may further impair performance and satisfaction and lead to secondary avoidance of sexual activity and impaired communication with the sexual partner.

Age at onset. The most common age at onset is early adult life, although Premature Ejaculation more commonly begins with the first sexual encounters. The most common age of clinical presentation is late 20s and early 30s, a few years after establishment of a sustained sexual relationship. However, the first appearance may be later in adult life, particularly with Inhibited Sexual Excitement in the male.

Course. The course is extremely variable. As previously noted, all of the dysfunctions may be lifelong or acquired (developing after a period of normal functioning). They may be limited to a single short-lived episode or a recurrent pattern of episodic dysfunction. Inhibited Sexual Desire may develop as a reaction to any of the other Psychosexual Dysfunctions.

Impairment. Psychosexual Dysfunctions, even when severe, are not associated with impairment in occupational functioning, but the relationship with a sexual partner may suffer.

Complications. The major complications consist of disrupted marital or other sexual relationships.

Predisposing factors. There appears to be a positive but slight correlation between certain personality traits and psychopathology in general and the presence of one or more Psychosexual Dysfunctions. Histrionic traits in women frequently are associated with Inhibited Sexual Excitement and Inhibited Orgasm. Compulsive traits in men frequently are associated with Inhibited Sexual Desire and Inhibited Sexual Excitement. Anxiety appears to predispose to the development of Premature Ejaculation. Any negative attitude toward sexuality, due to particular experiences, internal conflicts, or adherence to rigid subcultural values, predisposes to the Psychosexual Dysfunctions.

Prevalence. Although the exact prevalence is not known, most of these disorders are believed to be common, particularly in their milder forms.

Sex ratio. The sex ratio varies for the particular dysfunction. Inhibited Sexual Desire and Inhibited Orgasm are more common in females. Premature Ejaculation, as defined, is restricted to men. Functional Vaginismus, by definition, is restricted to women. Although Functional Dyspareunia is defined so that it can occur in males, it rarely does.

Familial pattern. No information.

Differential diagnosis. When a **physical disorder** partially accounts for the symptoms of a Psychosexual Dysfunction, provided that to some extent psychological factors are also contributing to the disturbance, both diagnoses should be given (the physical disorder is recorded on Axis III). For example, Inhibited Sexual Excitement judged to be partly secondary to diabetes can be diagnosed if it is judged that it is partly secondary to performance anxiety as well. The measurement of nocturnal penile tumescence associated with REM sleep is a useful diagnostic technique for evaluating the degree to which a physical disorder is etiologically related to the disturbance. When the disturbed sexual performance is chronic, unvarying over time, and independent of situation, this also suggests that a physical disorder may be etiologically related to the disturbance. In many instances the underlying physical disorder may not have been previously diagnosed.

If **another Axis I mental disorder,** for example, Major Depression, is the primary cause of a disturbance in sexual functioning, such as loss of sexual desire, a Psychosexual Dysfunction should not be diagnosed. However, in some instances it will not be clear whether the disturbance in sexual functioning antedates the other mental disorder (in which case it should also be diagnosed) or whether it is secondary to the other mental disorder (in which case it should not be diagnosed). Frequently a **Personality Disorder** may coexist with a Psychosexual Dysfunction and may even be conceptualized as etiologic. In such cases the Psychosexual Dysfunction should be recorded on Axis I and the Personality Disorder, on Axis II. If a **V code condition** such as Marital Problem or Other Interpersonal Problem is the primary cause of a disturbance in functioning, the Psychosexual Dysfunction should be diagnosed, and both conditions noted.

If there is **inadequate sexual stimulation,** in either focus, intensity, or duration, the diagnosis of Psychosexual Dysfunction involving excitement or orgasm is not made.

302.71 Inhibited Sexual Desire

Diagnostic criteria

A. Persistent and pervasive inhibition of sexual desire. The judgment of inhibition is made by the clinician's taking into account factors that affect sexual desire such as age, sex, health, intensity and frequency of sexual desire, and the context of the individual's life. In actual practice this diagnosis will rarely be made unless the lack of desire is a source of distress to either the individual or his or her partner. Frequently this category will be used in conjunction with one or more of the other Psychosexual Dysfunction categories.

B. The disturbance is not caused exclusively by organic factors (e.g., physical disorder or medication) and is not due to another Axis I disorder.

302.72 Inhibited Sexual Excitement

This has also been termed frigidity or impotence.

Diagnostic criteria

A. Recurrent and persistent inhibition of sexual excitement during sexual activity, manifested by:

In males, partial or complete failure to attain or maintain erection until completion of the sexual act, or

In females, partial or complete failure to attain or maintain the lubrication-swelling response of sexual excitement until completion of the sexual act.

B. A clinical judgment that the individual engages in sexual activity that is adequate in focus, intensity, and duration.

C. The disturbance is not caused exclusively by organic factors (e.g., physical disorder or medication) and is not due to another Axis I disorder.

302.73 Inhibited Female Orgasm

Diagnostic criteria

A. Recurrent and persistent inhibition of the female orgasm as manifested by a delay in or absence of orgasm following a normal sexual excitement phase during sexual activity that is judged by the clinician to be adequate in focus, intensity, and duration. The same individual may also meet the criteria for Inhibited Sexual Excitement if at other times there is a problem with the excitement phase of sexual activity. In such cases both categories of Psychosexual Dysfunction should be noted.

Some women are able to experience orgasm during noncoital clitoral stimulation, but are unable to experience it during coitus in the absence of manual clitoral stimulation. There is evidence to suggest that in some instances this represents a pathological inhibition that justifies this diagnosis whereas in other instances it represents a normal variation of the female sexual response. This difficult judgment is assisted by a thorough sexual evaluation, which may even require a trial of treatment.

B. The disturbance is not caused exclusively by organic factors (e.g., physical disorder or medication) and is not due to another Axis I disorder.

302.74 Inhibited Male Orgasm

Diagnostic criteria

A. Recurrent and persistent inhibition of the male orgasm as manifested by a delay in or absence of ejaculation following an adequate phase of sexual excitement. The same individual may also meet the criteria for Inhibited Sexual Excitement if at other times there is a problem with the excitement phase of sexual activity. In such cases both categories of Psychosexual Dysfunction should be noted.

B. The disturbance is not caused exclusively by organic factors (e.g., physical disorder or medication) and is not due to another Axis I disorder.

302.75 Premature Ejaculation

Diagnostic criteria

A. Ejaculation occurs before the individual wishes it, because of recurrent and persistent absence of reasonable voluntary control of ejaculation and orgasm during sexual activity. The judgment of "reasonable control" is made by the clinician's taking into account factors that affect duration of the excitement phase, such as age, novelty of the sexual partner, and the frequency and duration of coitus.

B. The disturbance is not due to another Axis I disorder.

302.76 Functional Dyspareunia

Diagnostic criteria

A. Coitus is associated with recurrent and persistent genital pain, in either the male or the female.

B. The disturbance is not caused exclusively by a physical disorder, and is not due to lack of lubrication, Functional Vaginismus, or another Axis I disorder.

306.51 Functional Vaginismus

Diagnostic criteria

A. There is a history of recurrent and persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with coitus.

B. The disturbance is not caused exclusively by a physical disorder, and is not due to another Axis I disorder.

302.70 Atypical Psychosexual Dysfunction

This category is for Psychosexual Dysfunctions that cannot be classified as a specific Psychosexual Dysfunction. An example would be no erotic sensations or even complete anesthesia despite normal physiological components of sexual excitement and orgasm. Another example would be a female analogue of Premature Ejaculation.

OTHER PSYCHOSEXUAL DISORDERS

302.00 Ego-dystonic Homosexuality

The essential features are a desire to acquire or increase heterosexual arousal, so that heterosexual relationships can be initiated or maintained, and a sustained pattern of overt homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

This category is reserved for those homosexuals for whom changing sexual orientations is a persistent concern, and should be avoided in cases where the desire to change sexual orientations may be a brief, temporary manifestation of an individual's difficulty in adjusting to a new awareness of his or her homosexual impulses.

Individuals with this disorder may have either no or very weak heterosexual arousal. Typically there is a history of unsuccessful attempts at initiating or sustaining heterosexual relationships. In some cases no attempt has been made to initiate a heterosexual relationship because of the expectation of lack of sexual responsiveness. In other cases the individual has been able to have short-lived heterosexual relationships, but complains that the heterosexual impulses are too weak to sustain such relationships. When the disorder is present in an adult, usually there is a strong desire to be able to have children and family life.

Generally individuals with this disorder have had homosexual relationships, but often the physical satisfaction is accompanied by emotional upset because of strong negative feelings regarding homosexuality. In some cases the negative feelings are so strong that the homosexual arousal has been confined to fantasy.

Associated features. Loneliness is particularly common. In addition, guilt, shame, anxiety, and depression may be present.

Age at onset. The most common age at onset is during early adolescence when the individual becomes aware that he or she is homosexually aroused and has already internalized negative feelings about homosexuality.

Course. There is some evidence that in time many individuals with this disorder give up the yearning to become heterosexual and accept themselves as homosexuals. This process is apparently facilitated by the presence of a supportive homosexual subculture. It is not known how often the disorder, without treatment, is self-limited. However, there is a general consensus that spontaneous development of a satisfactory heterosexual adjustment in individuals who previously had a sustained pattern of exclusively homosexual arousal is rare.

The extent to which therapy is able to decrease homosexual arousal, increase heterosexual arousal, or help homosexuals become satisfied with their sexuality is disputed.

Impairment. There is generally no or only mild impairment in social functioning.

Complications. Dysthymic Disorder can be a complication.

Predisposing factors. Since homosexuality itself is not considered a mental disorder, the factors that predispose to homosexuality are not included in this section. The factors that predispose to Ego-dystonic Homosexuality are those negative societal attitudes toward homosexuality that have been internalized. In addition, features associated with heterosexuality, such as having children and socially sanctioned family life, may be viewed as desirable and incompatible with a homosexual arousal pattern.

Prevalence, sex ratio, and familial pattern. No information.

Differential diagnosis. Homosexuality that is ego-syntonic is not classified as a mental disorder. In addition, the attitude that "I guess life would be easier if I were heterosexual" does not warrant this diagnosis. This category is reserved for homosexuals for whom changing sexual orientations is a persistent concern. Similarly, distress resulting simply from a conflict between a homosexual and society should not be classified here.

Individuals with **Inhibited Sexual Desire** may sometimes attribute the lack of sexual arousal to "latent homosexuality." However, Ego-dystonic Homosexuality should be diagnosed only when homosexual arousal is overt, although it may be limited to fantasy.

Homosexuals who develop a Major Depression may then express self-hatred because of their sexual orientation. The diagnosis of Ego-dystonic Homosexuality should not be made if the ego-dystonic quality is judged to be only a transient symptom of a Depressive Disorder.

Diagnostic criteria for Ego-dystonic Homosexuality

A. The individual complains that heterosexual arousal is persistently absent or weak and significantly interferes with initiating or maintaining wanted heterosexual relationships.

B. There is a sustained pattern of homosexual arousal that the individual explicitly states has been unwanted and a persistent source of distress.

302.89 Psychosexual Disorder Not Elsewhere Classified

This is a residual category for disorders whose chief manifestations are psychological disturbances related to sexuality not covered by any of the other

specific categories in the diagnostic class of Psychosexual Disorders. In rare instances this category may be used concurrently with one of the specific diagnoses when both diagnoses are necessary to explain or describe the clinical disturbance.

Examples include the following:

(1) marked feelings of inadequacy related to self-imposed standards of masculinity or femininity, such as body habitus, size and shape of sex organs, or sexual performance;

(2) impaired pleasure during the normal physiological pelvic responses of orgasm;

(3) distress about a pattern of repeated sexual conquests with a succession of individuals who exist only as things to be used (Don Juanism and nymphomania);

(4) confusion about preferred sexual orientation.

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Factitious Disorders

"Factitious" means not real, genuine, or natural. Factitious Disorders are therefore characterized by physical or psychological symptoms that are produced by the individual and are under voluntary control. The sense of voluntary control is subjective, and can only be inferred by an outside observer.

The judgment that the behavior is under voluntary control is based, in part, on the patient's ability to simulate illness in such a way that he or she is not discovered. This involves decisions as to timing and concealment that require a degree of judgment and intellectual activity suggestive of voluntary control. However, these acts have a compulsive quality, in the sense that the individual is unable to refrain from a particular behavior, even if its dangers are known. They should therefore be considered "voluntary" in the sense that they are deliberate and purposeful, but not in the sense that the acts can be controlled. Thus, in Factitious Disorders, behavior under voluntary control is used to pursue goals that are involuntarily adopted.

The judgment that a particular behavior is under voluntary control is made by the exclusion of all other possible causes of the behavior. For example, an individual presenting with hematuria is found to have anticoagulants in his possession; he denies having taken them, but blood studies are consistent with the ingestion of the anticoagulants. A reasonable inference is that the individual may have voluntarily taken the medication. A single episode of such behavior could be accidental rather than intentional. Repeated episodes would justify an inference of voluntary production of the symptoms—a Factitious Disorder. The presence of factitious psychological or physical symptoms does not preclude the coexistence of true psychological or physical symptoms.

Factitious Disorders are distinguished from acts of malingering. In Malingering, the "patient" is also in voluntary control of the symptoms, but it is for a goal that is obviously recognizable with a knowledge of the environmental circumstances, rather than of his or her psychology. For example, a claim of physical illness in order to avoid jury duty, standing trial, or conscription into the military would be classified as Malingering. Similarly, for a patient in a mental hospital to simulate an exacerbation of his or her illness in order to avoid transfer to another, less desirable facility would be an act of malingering. In contrast, in a Factitious Disorder there is no apparent goal other than to assume the patient role. If the patient mentioned above were being transferred to an obviously more desirable facility, his or her simulated exacerbation of symptoms would be a Factitious Disorder. Whereas an act of malingering may, under certain circumstances, be considered adaptive, by definition a diagnosis of a Factitious Disorder always implies psychopathology, most often a severe personality disturbance.

In the past, some of the disorders classified here would have been subsumed within the category of Hysteria.

Factitious Disorders may present with psychological or physical symptoms. Chronic Factitious Disorder with Physical Symptoms, often referred to as Munchausen syndrome, is the best known and most frequently reported of the Factitious Disorders. The other two categories included in this section are Factitious Disorder with Psychological Symptoms and Atypical Factitious Disorder with Physical Symptoms.

300.16 Factitious Disorder with Psychological Symptoms

The essential feature is the voluntary production of severe psychological (often psychotic) symptoms, suggestive of mental disorder. The individual's goal is apparently to assume the "patient" role and is not otherwise understandable in light of the individual's environmental circumstances (as is the case in Malingering). This has also been referred to as Ganser syndrome, pseudopsychosis, or pseudodementia.

This disorder is often recognized by the pan-symptomatic complex of psychological symptoms that are presented and by the fact that the symptoms are worse when the individual is aware of being observed. Such an individual may claim memory loss (recent and remote), hallucinations (auditory and visual), and dissociative and conversion symptoms, along with suicidal ideation. The same individual may be extremely suggestible and admit to many additional symptoms asked about by the examiner. Conversely, the individual may be extremely negativistic and uncooperative to further questioning. The psychological symptoms presented are usually a representation of the person's concept of mental disorder and may not conform to any of the recognized diagnostic categories.

Associated features. *"Vorbeireden,"* the symptom of giving approximate answers or talking past the point, may be present. This is to be considered when the person gives answers to questions involving intellectual functions (such as calculations) that consistently are near misses of the correct response. When asked to multiply eight times eight, such a person may answer "sixty-five." This phenomenon, however, is not specific for this disorder, and may be found in individuals with Schizophrenia or in persons without mental disorders who are exhausted or are being humorous.

Factitious Disorder with Psychological Symptoms is almost always superimposed on a severe Personality Disorder. The individual may secretly use substances for the purpose of producing symptoms that suggest nonorganic mental disorder. Stimulants (amphetamines, cocaine, or caffeine) may be used to produce restlessness or insomnia; hallucinogens (LSD, mescaline, THC) to induce altered levels of consciousness and perception; analgesics (heroin, morphine) to induce euphoria; hypnotics (barbiturates, alcohol), to induce lethargy. Combinations of the above substances can produce very bizarre presentations.

Age at onset, prevalence, and familial pattern. No information.

Sex ratio. The disorder is apparently more common in males.

Predisposing factors. Severe Personality Disorder is a predisposing factor.

Course. The course may be limited to one or more brief episodes, or may be chronic.

Impairment. Impairment tends to be severe.

Complications. Frequent hospitalizations are a complication.

Differential diagnosis. Differential diagnosis of this disorder from other mental disorders is extremely difficult. The clinician may notice that the total clinical picture is not characteristic of any recognized mental disorder. Psychological tests (e.g., projective tests, or the Bender-Gestalt) may be helpful when the responses elicited suggest a mixture of perceptual, cognitive, and intellectual impairment that is not characteristic of any mental disorder but suggests, rather, the individual's concept of mental disorder. There is the danger, however, that simulated bizarre responses will be taken at face value.

A true **Dementia** frequently has a demonstrable organic etiology or pathophysiological process. In "pseudo"-dementia there are often near-miss, approximate answers rather than gross inability to answer questions correctly, as is often the case in a Factitious Disorder.

In a **true psychosis,** such as **Brief Reactive Psychosis or Schizophreniform Disorder,** the individual's behavior on the ward generally will not differ markedly from his or her behavior in the clinician's office. In contrast, in a Factitious Disorder with psychotic features the individual may appear to respond to auditory hallucinations only when under the impression that he or she is being watched.

For a discussion of the differential diagnosis with **Malingering,** see p. 331.

Diagnostic criteria for Factitious Disorder with Psychological Symptoms

A. The production of psychological symptoms is apparently under the individual's voluntary control.

B. The symptoms produced are not explained by any other mental disorder (although they may be superimposed on one).

C. The individual's goal is apparently to assume the "patient" role and is not otherwise understandable in light of the individual's environmental circumstances (as is the case in Malingering).

Factitious Disorder with Physical Symptoms

The essential feature is the presentation of physical symptoms that are not real. The presentation may be total fabrication, as in complaints of acute abdominal pain in the absence of any such pain; self-inflicted, as in the production of abscesses by injection of saliva into the skin; an exaggeration or exacerbation