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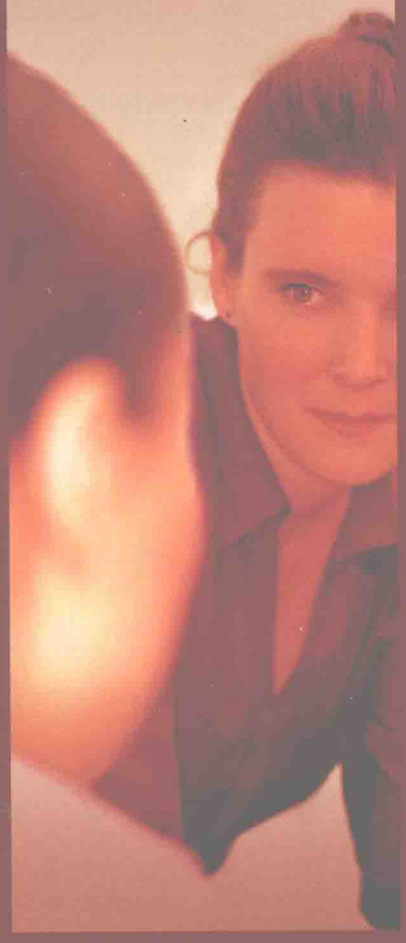
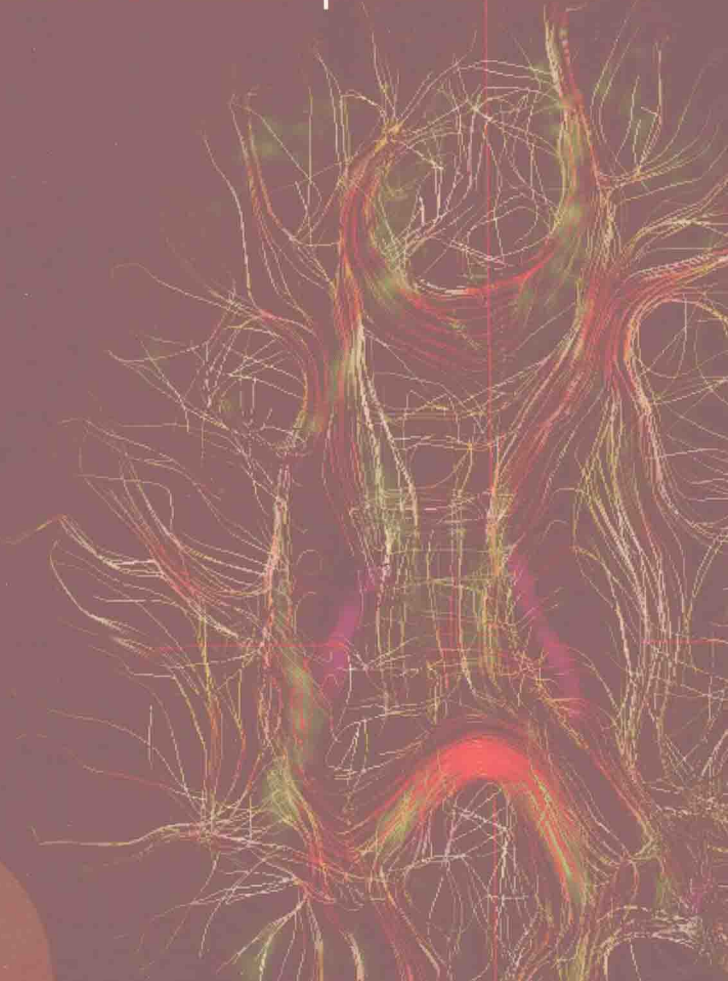


# Clinical Guide to the Diagnosis and Treatment of Mental Disorders

Michael B. First | Allan Tasman



• FIRST
• TASMAN

# Clinical Guide to the Diagnosis and Treatment of Mental Disorders

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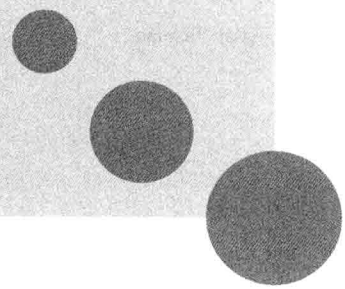

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## Dedications

To Leslee, my bashert

**Michael**

With love and thanks to my family, in particular to my father, Goodman Tasman, for your support and inspiration

**Allan**

# Preface

The publication of DSM-III in 1980 revolutionized psychiatry. Among its many accomplishments (e.g., increased diagnostic reliability), it provided both a common language for naming, describing, and identifying the complete range of mental disorders seen in clinical practice, as well as an organizational plan embodied in the diagnostic groupings contained in the DSM-III classification (i.e., grouping together Organic Mental Disorders, Psychotic Disorders, Mood Disorder, Anxiety Disorders, etc.) Its appeal is several-fold: (1) it is *authoritative*; the information contained in the DSM is authored by the leading experts in psychiatry and psychology; (2) it is *comprehensive*: all disorders seen by mental health professionals are covered in the DSM; (3) it is *clinically useful*: material included in the DSM is intended to be of practical use in making psychiatric diagnoses; (4) it is *educational*: material is included also for the purpose of educating the reader about mental disorders, such as how they present, sex ratio, prevalence rates; and (5) it is *relatively concise*: all the information is contained in a single volume, of around 900 pages in length.

Although the DSM is indispensable in the evaluation and treatment of individuals with mental disorders, arriving at a psychiatric diagnosis is only the first step in the process. Once the clinician determines the diagnosis, he or she must then choose from among a range of available treatment options. Certainly the biggest limitation of the DSM-IV-TR is its omission of any information about the management and treatment of individuals with mental disorders. DSM-IV-TR users must turn elsewhere for information about which treatment to choose—either to books written specifically about the treatment of a disorder or books covering treatment in general. *DSM-IV-TR Mental Disorders: Diagnosis, Etiology, and Treatment* (edited by First and Tasman), adapted from Section 5 of the two-volume textbook *Psychiatry*, 2nd edition (edited by Tasman, Kay, and Lieberman), was published in May 2004 and combined information about the diagnosis, etiology, and treatment of mental disorders into a single volume. Unfortunately, its length and cost greatly limited its utility as a helpful guide for students and practicing clinicians. This *Clinical Guide to the Diagnosis and Treatment of Mental Disorders* arises from our efforts to create a more concise and more clinician-friendly version of the original First and Tasman book.

This book retains the breadth of the *Diagnosis, Etiology, and Treatment* book but not the depth—we will continue to have the same number of chapters which cover all of the disorders in the DSM-IV-TR but the content has been edited to meet the clinical needs of the readership. Rather than serving as a reference book about mental disorders, we see this book as an accessible clinical guide to diagnosis and treatment. As such, the "Etiology" sections from the original book have been eliminated and the "Diagnosis" and "Treatment" sections have been condensed with the goal of retaining only information which is clinically relevant. In addition, details of studies establishing the epidemiology of the disorders or the efficacy of treatments have been removed, as have all of the references. Readers interested in this information should refer to the corresponding chapters in the original book.

The organization of the chapters in this book closely parallels the layout of disorders in the DSM-IV-TR. The amount of space allocated to each disorder in this book varies according to clinical importance. Thus, unlike DSM-IV-TR, in which all of the anxiety disorders are covered in the same chapter, the book splits up the major anxiety disorders among several different chapters. Within each chapter, this book for the most part follows a consistent structure. The "Diagnosis" section for each disorder begins with introductory material describing the features of the disorder and includes information about assessment issues, comorbid conditions, associated features, epidemiology, course (which includes age at onset, prognosis, and outcome), and differential diagnosis. The "Treatment" sections summarize the available treatments for the disorders, and often are broken down into "Somatic Treatments" and "Psychosocial Treatments" for ease of reference.

The factual content of the chapters in this book has been adapted from the "Disorders" section of the 2nd edition of the two-volume Tasman, Kay, and Lieberman textbook *Psychiatry*, which was published by Wiley in 2003. We would like to acknowledge the excellent contributions made by the original contributors to these chapters, who are listed in the Acknowledgments of this book. Two new chapters, covering Amphetamine-Related Disorders by Kevin

Sevarino and Reactive Attachment Disorder by Brian Stafford and Charles Zeanah were developed for the original First and Tasman book (and thus are included in an edited form here), as no chapters covering these disorders were included in the original two-volume textbook. We would also like to express our gratitude to Deborah Russell and Andrea Baier at John Wiley & Sons for their help in the editing and production of this book.

Michael B. First
Allan Tasman

April 2006

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We would like to gratefully acknowledge the authors of those chapters in *Psychiatry*, 2nd edition from which material in this book was adapted.

| | |
|---|---|
| Henry David Abraham | *Substance Abuse: Hallucinogen- and MDMA-Related Disorders* |
| Sonia Ancoli-Israel | *Sleep and Sleep–Wake Disorders* |
| Martin M. Antony | *Anxiety Disorders: Social and Specific Phobias* |
| Gordon J. G. Asmundson | *Anxiety Disorders: Panic Disorder with and without Agoraphobia* |
| Thomas F. Babor | *Substance Abuse: Alcohol Use Disorders* |
| Mark S. Bauer | *Mood Disorders: Bipolar (Manic–Depressive) Disorders* |
| Jean C. Beckham | *Anxiety Disorders: Traumatic Stress Disorders* |
| Olga Brawman-Mintzer | *Anxiety Disorders: Generalized Anxiety Disorder* |
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| Amanda J. Gruber | *Substance Abuse: Cannabis-Related Disorders* |
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| Steven Taylor | *Anxiety Disorders: Panic Disorder with and without Agoraphobia* |
| Jane A. Ungemack | *Substance Abuse: Alcohol Use Disorders* |
| John T. Walkup | *Childhood Disorders: Tic Disorders* |
| B. Timothy Walsh | *Eating Disorders* |
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| Maija Wilska | *Childhood Disorders: Mental Retardation* |
| Ronald M. Winchel | *Impulse Control Disorders* |
| George E. Woody | *Substance Abuse: Opioid Use Disorder* |
| Yoram Yovell | *Impulse Control Disorders* |
| Sean H. Yutzy | *Somatoform Disorders* |
| Douglas Ziedonis | *Substance Abuse: Nicotine Dependence* |
| Stephen R. Zukin | *Substance Abuse: Phencyclidine Use Disorders* |
| Ilana Zylberman | *Substance Abuse: Phencyclidine Use Disorders* |

CHAPTER 1

# Psychiatric Diagnosis

There is a natural human predilection to categorize and classify in order to simplify and organize the wide range of observable phenomena and experiences that one is confronted with, thus facilitating both their understanding and their predictability. Many (if not most) of the mental disorders that afflict contemporary individuals have occurred in antiquity. For example, the first recorded depiction of mental illness dates to 3000 B.C. Egypt, with a description of the syndrome senile dementia attributed to Prince Ptah-hotep. The current system for the diagnosis of mental disorders, the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition Text Revision (DSM-IV-TR), is just the latest example from the long and colorful history of psychiatric classification.

## GOALS OF THE DSM-IV-TR

Perhaps the most important goal of the DSM-IV-TR is to allow mental health practitioners and researchers to communicate more effectively with each other by establishing a convenient shorthand for describing the mental disorders that they encounter. For example, telling a colleague that an individual whom you have just evaluated has major depressive disorder can convey a great deal of information in only a few words. First of all, it indicates that depressed mood or loss of interest is a central aspect of the presenting problem and that the depression is not the kind of "normal" mood fluctuation that lasts for only a few days but rather that it persists every day for an extended period of time, for at least 2 weeks. Furthermore, one can expect to find a number of additional symptoms occurring at the same time, like suicidal ideation and changes in appetite, sleep, energy, and psychomotor activity. Finally, information is also communicated about what is not to be found in this individual—specifically, that the depression is not caused by the direct physiological effects of alcohol, other drugs, medications, or a general medical condition; and that there is no history of schizophrenia or manic or hypomanic episodes.

DSM-IV-TR also facilitates the identification and management of mental disorders in both clinical and research settings. Most of the DSM-IV-TR diagnostic labels provide considerable and important predictive power. For example, making a diagnosis of bipolar disorder suggests the choice of treatment options (e.g., mood stabilizers), that a certain course may be likely (e.g., recurrent and episodic), and that there is an increased prevalence of this disorder in family members. By defining more or less homogeneous groups of individuals for study, DSM-IV-TR can also further efforts to understand the etiology of mental disorders. DSM-IV-TR also plays an important role in education. In its organization of disorders into major classes, the system offers a structure for teaching phenomenology and differential diagnosis. DSM-IV-TR is also useful in psychoeducation by showing individuals suffering from symptoms of a mental disorder that their pattern of symptoms is not mysterious and unique but rather has been identified and studied in others.

## DSM-IV-TR OVERVIEW

The remainder of this chapter provides an overview of the DSM-IV-TR multiaxial system as well as a presentation of some of the organizational principles of the various diagnostic groupings included in the DSM-IV-TR classification. The chapters in this book are organized according to their presentation in the DSM-IV-TR classification and provide detailed information regarding the diagnosis, epidemiology, course, and treatment of these disorders.

## DSM-IV-TR MULTIAXIAL SYSTEM

The multiaxial system was first introduced by DSM-III in order to encourage the clinician to focus his or her attention during the evaluation process on issues above and beyond the psychiatric diagnosis. Use of the multiaxial system requires that information be noted on each of the five different axes, each axis

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devoted to a different aspect of the evaluation process. Axes I, II, and III are the diagnostic axes that divide up the diagnostic pie into three separate domains. Axis I is for "clinical syndromes and disorders," an admittedly confusing name since Axis II and Axis III also include clinical disorders. The most accurate name for Axis I is "diagnoses not coded on Axis II and Axis III," since Axis II and Axis III were carved out of Axis I specifically to draw attention to certain disorders that clinicians were more likely to overlook.

That said, Axis II is designated for coding personality disorders and traits and mental retardation. There have been many recent criticisms of the coding of personality disorders on Axis II. Critics correctly point out that there is no firm conceptual basis for this division. Although disorders on Axis II tend to be lifelong and pervasive, a number of disorders on Axis I (e.g., schizophrenia, autistic disorder, dysthymic disorder) fit this description as well. Others have made the incorrect assumption that categories on Axis II are unresponsive to medication treatment, which is at odds with more recent evidence that medications are often helpful in the treatment of personality disorders. The fact is that the Axis I/Axis II division is strictly pragmatic. First introduced in DSM-III, Axis II was designed to draw attention to certain disorders that were thought to be overshadowed in the face of the more florid Axis I presentations. In DSM-III, Axis II was reserved for personality disorders in adults and specific developmental disorders in children. In DSM-III-R, all of the developmental disorders (i.e., mental retardation, pervasive developmental disorders, specific developmental disorders) were coded on Axis II along with the personality disorders. In DSM-IV-TR, Axis II was modified once again so that only personality disorders and traits and mental retardation remain on Axis II. Certainly the placement of personality disorders on a separate axis has increased both their clinical visibility and their importance as a subject for research studies. Whether the Axis I/Axis II division has finally outlived its usefulness remains a topic of heated debate and will be revisited during the DSM-V deliberations.

Axis III, like Axis II, is intended to encourage clinicians to pay special attention to conditions that they tend to overlook, in this case, clinically relevant general medical conditions. The concept of "clinically relevant" is intended to be broad. For example, it would be appropriate to list hypertension on Axis III even if its only relationship to an Axis I disorder is its impact on the options for the choice of antidepressant medication.

Psychosocial stressors are well known to play an important role in the etiology, maintenance, and management of a number of mental disorders. Axis IV provides the clinician with the opportunity to list clinically relevant psychosocial and environmental problems (e.g., homelessness, poverty, divorce). To facilitate a comprehensive evaluation of such problems, DSM-IV-TR includes a psychosocial and environmental checklist that allows the clinician to indicate which types of problems are present and relevant (Figure 1-1).

Mental disorders differentially impact on the individual's level of functioning. For example, one individual with schizophrenia may function quite well, being able to live in the community, marry and have a family, and maintain a steady job, whereas another individual with schizophrenia may function quite poorly, requiring chronic institutionalization. Since both of these individuals have symptoms that meet the diagnostic criteria for schizophrenia, their important differences in functioning are not captured by the clinical diagnosis alone. Some of the differences in functioning may be due to different symptom profiles or symptom severities. Other differences may be related to resilience factors or different levels of psychosocial support. Whatever the reason, the DSM-IV-TR multiaxial system provides the clinician with the ability to indicate the individual's overall level of functioning in addition to the diagnosis

Check:

__ Problems with primary support group (childhood, adult, parent–child). Specify: _____

__ Problems related to the social environment. Specify: _____

__ Educational problems. Specify: _____

__ Occupational problems. Specify: _____

__ Housing problems. Specify: _____

__ Economic problems. Specify: _____

__ Problems with access to health care services. Specify: _____

__ Problems related to interaction with the legal system/crime. Specify: _____

__ Other psychosocial problems. Specify: _____

**Figure 1-1** *DSM-IV-TR Axis IV: psychosocial and environmental checklist. (Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, pp36, Copyright 2000. American Psychiatric Association.)*

on Axis V, using the Global Assessment of Functioning (GAF) Scale (Figure 1-2). This GAF Scale has been criticized because it is not actually a "pure" measure of an individual's ability to function since it incorporates symptom severity into the scale; for example, level 41 to 50 is for serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job). For this reason, the DSM-IV-TR includes a scale (the Social and Occupational Functioning Scale [SOFAS]) that relies exclusively on functioning in its appendix

## Global Assessment of Functioning (GAF) Scale

Consider psychological, social and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

| Code | (Note: Use intermediate codes when appropriate, e.g., 45,68,72.) |
|---|---|
| 100 | **Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of many positive qualities.** |
| 91 | **No symptoms.** |
| 90 | **Absent or minimal symptoms** (e.g., mild anxiety before an examination), **good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns** (e.g., an occasional argument with family |
| 81 | members). |
| 80 | **If symptoms are present, they are transient and expectable reactions to psychosocial stressors** (e.g., difficulty concentrating after family argument); **no more than slight impairment in social, occupational, or school functioning** |
| 71 | (e.g., temporarily falling behind in school work). |
| 70 | **Some mild symptoms** (e.g., depressed mood and mild insomnia) **OR some difficulty in social, occupational, or school functioning** (e.g., occasional truancy, or theft within the household), **but generally functioning pretty** |
| 61 | **well, has some meaningful interpersonal relationships.** |
| 60 | **Moderate symptoms** (e.g., flat affect and circumstantial speech, occasional panic attacks) **OR moderate difficulty in social, occupational, or school** |
| 51 | **functioning** (e.g., few friends, conflicts with peers or coworkers). |
| 50 | **Serious symptoms** (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) **OR any serious impairment in social, occupational, or school** |
| 41 | **functioning** (e.g., no friends, unable to keep a job). |
| 40 | **Some impairment in reality testing or communication** (e.g., speech is at times illogical, obscure, or irrelevant) **OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood** (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up |
| 31 | younger children, is defiant at home, and is failing at school). |
| 30 | **Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment** (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) **OR inability to function in almost** |
| 21 | **all areas** (e.g., stays in bed all day; no job, home or friends). |
| 20 | **Some danger of hurting self or others** (e.g., suicide attempts without clear expectation of death, frequently violent, manic excitement) **OR occasionally fails to maintain minimal personal hygiene** (e.g., smears feces) **OR gross impairment in** |
| 11 | **communication** (e.g., largely incoherent or mute). |
| 10 | **Persistent danger of severely hurting self or others** (e.g., recurrent violence) **OR persistent inability to maintain minimal personal hygiene OR serious suicidal** |
| 1 | **act with clear expectation of death.** |
| 0 | Inadequate information |

**Figure 1-2** *DSM-IV-TR Axis V: Global Assessment Functioning Scale. (Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, pp34, Copyright 2000. American Psychiatric Association.)*

| Table 1-1 | Example of DSM-IV-TR Multiaxial Evaluation |
|---|---|
| Axis I | 296.23 Major depressive disorder, single episode, severe but without psychotic features, with postpartum onset. |
| | 307.51 Bulimia nervosa |
| Axis II | 301.6 Dependent personality disorder |
| | Frequent use of denial |
| Axis III | Rheumatoid arthritis |
| Axis IV | Partner relational problem |
| Axis V | GAF = 35 (current) |

of Criteria Sets and Axes Provided for Further Study. An example of a DSM-IV-TR multiaxial evaluation for a hypothetical individual with depression is shown in Table 1.1.

## DSM-IV-TR CLASSIFICATION AND DIAGNOSTIC CODES

The "DSM-IV-TR Classification of Mental Disorders" refers to the comprehensive listing of the official diagnostic codes, categories, subtypes, and specifiers (see below). It is divided into various "diagnostic classes" that group disorders together on the basis of common presenting symptoms (e.g., mood disorders, anxiety disorders), typical age at onset (e.g., disorders usually first diagnosed in infancy, childhood, and adolescence), and etiology (e.g., substance-related disorders, mental disorders due to a general medical condition).

The diagnostic codes listed in the DSM-IV-TR are derived from the *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), the official coding system for reporting morbidity and mortality in the United States. That is the reason the codes go from 290.00 to 319.00; they are actually derived from the mental disorders section of a much larger coding system for all medical disorders that extend from 001 to 999. Clinicians working in the United States are required to use ICD-9-CM in order to get reimbursement from both government agencies (e.g., Medicare and Medicaid) and private insurers. To insure that users of the DSM-IV-TR are able to meet this requirement without doing any cumbersome code conversions, the DSM-IV-TR contains the current ICD-9-CM codes. Because the ICD-9-CM codes are updated on a yearly basis (i.e., every October 1), the DSM-IV-TR codes have to be similarly updated as changes to the codes in the ICD-9-CM mental disorder section occur. Successive printings of DSM-IV-TR have been modified to include these updated codes. In addition, updated diagnostic codes are available on the DSM-IV-TR web site (www.dsm4tr.org)

## DSM-IV-TR Classification

NOS = Not Otherwise Specified.

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

An ellipsis (...) is used in the names of certain disorders to indicate that the name of a specific mental disorder or general medical condition should be inserted when recording the name (e.g., 293.0 Delirium Due to Hypothyroidism).

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

Mild
Moderate
Severe

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

In Partial Remission
In Full Remission
Prior History

## Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

### MENTAL RETARDATION

Note: *These are coded on Axis II.*

317 Mild Mental Retardation
318.0 Moderate Mental Retardation
318.1 Severe Mental Retardation
318.2 Profound Mental Retardation
319 Mental Retardation, Severity Unspecified

### LEARNING DISORDERS

315.00 Reading Disorder
315.1 Mathematics Disorder
315.2 Disorder of Written Expression
315.9 Learning Disorder NOS

### MOTOR SKILLS DISORDER

315.4 Developmental Coordination Disorder

### COMMUNICATION DISORDERS

315.31 Expressive Language Disorder
315.32 Mixed Receptive–Expressive Language Disorder
315.39 Phonological Disorder
307.0 Stuttering
307.9 Communication Disorder NOS

### PERVASIVE DEVELOPMENTAL DISORDERS

299.00 Autistic Disorder
299.80 Rett's Disorder
299.10 Childhood Disintegrative Disorder
299.80 Asperger's Disorder
299.80 Pervasive Developmental Disorder NOS

### ATTENTION-DEFICIT AND DISRUPTIVE BEHAVIOR DISORDERS

314.xx Attention-Deficit/Hyperactivity Disorder
.01 Combined Type
.00 Predominantly Inattentive Type
.01 Predominantly Hyperactive-Impulsive Type
314.9 Attention-Deficit/Hyperactivity Disorder NOS
312.xx Conduct Disorder
.81 Childhood-Onset Type
.82 Adolescent-Onset Type
.89 Unspecified Onset
313.81 Oppositional-Defiant Disorder
312.9 Disruptive Behavior Disorder NOS

### FEEDING AND EATING DISORDERS OF INFANCY OR EARLY CHILDHOOD

307.52 Pica
307.53 Rumination Disorder
307.59 Feeding Disorder of Infancy or Early Childhood

### TIC DISORDERS

307.23 Tourette's Disorder
307.22 Chronic Motor or Vocal Tic Disorder
307.21 Transient Tic Disorder
*Specify if*: Single Episode/Recurrent
307.20 Tic Disorder NOS

### ELIMINATION DISORDERS

—.— Encopresis
787.6 With Constipation and Overflow Incontinence
307.7 Without Constipation and Overflow Incontinence
307.6 Enuresis (Not Due to a General Medical Condition)
*Specify type*: Nocturnal Only/Diurnal Only/Nocturnal and Diurnal

### OTHER DISORDERS OF INFANCY, CHILDHOOD, OR ADOLESCENCE

309.21 Separation Anxiety Disorder
*Specify if*: Early Onset
313.23 Selective Mutism
313.89 Reactive Attachment Disorder of Infancy or Early Childhood
*Specify type*: Inhibited Type/Disinhibited Type
307.3 Stereotypic Movement Disorder
*Specify if*: With Self-Injurious Behavior
313.9 Disorder of Infancy, Childhood, or Adolescence NOS

## Delirium, Dementia, and Amnestic and Other Cognitive Disorders

### DELIRIUM

293.0 Delirium Due to... [*Indicate the General Medical Condition*]
—.— Substance Intoxication Delirium (*refer to Substance-Related Disorders for substance-specific codes*)
—.— Substance Withdrawal Delirium (*refer to Substance-Related Disorders for substance-specific codes*)
—.— Delirium Due to Multiple Etiologies (*code each of the specific etiologies*)
780.09 Delirium NOS

### DEMENTIA

294.xx Dementia of the Alzheimer's Type, With Early Onset (*also code 331.0 Alzheimer's disease on Axis III*)
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
294.xx Dementia of the Alzheimer's Type, With Late Onset (*also code 331.0 Alzheimer's disease on Axis III*)
.10 Without Behavioral Disturbance
.11 With Behavioral Disturbance
290.xx Vascular Dementia
.40 Uncomplicated
.41 With Delirium
.42 With Delusions
.43 With Depressed Mood
*Specify if*: With Behavioral Disturbance

*Code presence or absence of a behavioral disturbance in the fifth digit for Dementia Due to a General Medical Condition*:

294.10 = Without Behavioral Disturbance
294.11 = With Behavioral Disturbance
294.1x Dementia Due to HIV Disease (*also code 042 HIV on Axis III*)
294.1x Dementia Due to Head Trauma (*also code 854.00 head injury on Axis III*)
294.1x Dementia Due to Parkinson's Disease (*also code 331.82 Dementia with Lewy Bodies on Axis III*)
294.1x Dementia Due to Huntington's Disease (*also code 333.4 Huntington's disease on Axis III*)
294.1x Dementia Due to Pick's Disease (*also code 331.11 Pick's disease on Axis III*)
294.1x Dementia Due to Creutzfeldt–Jakob Disease (*also code 046.1 Creutzfeldt–Jakob disease on Axis III*)
294.1x Dementia Due to ... [*Indicate the General Medical Condition not listed above*] (*also code the general medical condition on Axis III*)
—.— Substance-Induced Persisting Dementia (*refer to Substance-Related Disorders for substance-specific codes*)
—.— Dementia Due to Multiple Etiologies (*code each of the specific etiologies*)
294.8 Dementia NOS

## AMNESTIC DISORDERS

294.0 Amnestic Disorder Due to ... [*Indicate the General Medical Condition*]
*Specify if*: Transient/Chronic
—.— Substance-Induced Persisting Amnestic Disorder (*refer to Substance-Related Disorders for substance-specific codes*)
294.8 Amnestic Disorder NOS

## OTHER COGNITIVE DISORDERS

294.9 Cognitive Disorder NOS

### Mental Disorders Due to a General Medical Condition Not Elsewhere Classified

293.89 Catatonic Disorder Due to ... [*Indicate the General Medical Condition*]
310.1 Personality Change Due to ... [*Indicate the General Medical Condition*]
*Specify type*: Labile Type/Disinhibited Type/Aggressive Type/Apathetic Type/Paranoid Type/Other Type/Combined Type/Unspecified Type
293.9 Mental Disorder NOS Due to ... [*Indicate the General Medical Condition*]

### Substance-Related Disorders

*The following specifiers apply to Substance Dependence as noted:*
[a]With Physiological Dependence/Without Physiological Dependence
[b]Early Full Remission/Early Partial Remission/Sustained Full Remission/Sustained Partial Remission
[c]In a Controlled Environment
[d]On Agonist Therapy
*The following specifiers apply to Substance-Induced Disorders as noted:*
[I]With Onset During Intoxication/[W]With Onset During Withdrawal

## ALCOHOL-RELATED DISORDERS

### Alcohol Use Disorders

303.90 Alcohol Dependence[a,b,c]
305.00 Alcohol Abuse

### Alcohol-Induced Disorders

303.00 Alcohol Intoxication
291.81 Alcohol Withdrawal
*Specify if*: With Perceptual Disturbances
291.0 Alcohol Intoxication Delirium
291.0 Alcohol Withdrawal Delirium
291.2 Alcohol-Induced Persisting Dementia
291.1 Alcohol-Induced Persisting Amnestic Disorder
291.x Alcohol-Induced Psychotic Disorder
.5 With Delusions[I,W]
.3 With Hallucinations[I,W]
291.89 Alcohol-Induced Mood Disorder[I,W]
291.89 Alcohol-Induced Anxiety Disorder[I,W]
291.89 Alcohol-Induced Sexual Dysfunction[I]
291.82 Alcohol-Induced Sleep Disorder[I,W]
291.9 Alcohol-Related Disorder NOS

## AMPHETAMINE (OR AMPHETAMINE-LIKE)-RELATED DISORDERS

### Amphetamine Use Disorders

304.40 Amphetamine Dependence[a,b,c]
305.70 Amphetamine Abuse

### Amphetamine-Induced Disorders

292.89 Amphetamine Intoxication
*Specify if*: With Perceptual Disturbances
292.0 Amphetamine Withdrawal
292.81 Amphetamine Intoxication Delirium
292.xx Amphetamine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Amphetamine-Induced Mood Disorder[I,W]
292.89 Amphetamine-Induced Anxiety Disorder[I]
292.89 Amphetamine-Induced Sexual Dysfunction[I]
292.85 Amphetamine-Induced Sleep Disorder[I,W]
292.9 Amphetamine-Related Disorder NOS

## CAFFEINE-RELATED DISORDERS

### Caffeine-Induced Disorders

305.90 Caffeine Intoxication
292.89 Caffeine-Induced Anxiety Disorder[I]
292.85 Caffeine-Induced Sleep Disorder[I]
292.9 Caffeine-Related Disorder NOS

## CANNABIS-RELATED DISORDERS

### Cannabis Use Disorders

304.30 Cannabis Dependence[a,b,c]
305.20 Cannabis Abuse

### Cannabis-Induced Disorders

292.89 Cannabis Intoxication
*Specify if*: With Perceptual Disturbances
292.81 Cannabis Intoxication Delirium
292.xx Cannabis-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.89 Cannabis-Induced Anxiety Disorder[I]
292.9 Cannabis-Related Disorder NOS

## COCAINE-RELATED DISORDERS

### Cocaine Use Disorders

304.20 Cocaine Dependence[a,b,c]
305.60 Cocaine Abuse

### Cocaine-Induced Disorders

292.89 Cocaine Intoxication
*Specify if*: With Perceptual Disturbances
292.0 Cocaine Withdrawal
292.81 Cocaine Intoxication Delirium
292.xx Cocaine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Cocaine-Induced Mood Disorder[I,W]
292.89 Cocaine-Induced Anxiety Disorder[I,W]
292.89 Cocaine-Induced Sexual Dysfunction[I]
292.85 Cocaine-Induced Sleep Disorder[I,W]
292.9 Cocaine-Related Disorder NOS

## HALLUCINOGEN-RELATED DISORDERS

### Hallucinogen Use Disorders

304.50 Hallucinogen Dependence[b,c]
305.30 Hallucinogen Abuse

### Hallucinogen-Induced Disorders

292.89 Hallucinogen Intoxication
292.89 Hallucinogen Persisting Perception Disorder (Flashbacks)
292.81 Hallucinogen Intoxication Delirium
292.xx Hallucinogen-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Hallucinogen-Induced Mood Disorder[I]
292.89 Hallucinogen-Induced Anxiety Disorder[I]
292.9 Hallucinogen-Related Disorder NOS

## INHALANT-RELATED DISORDERS

### Inhalant Use Disorders

304.60 Inhalant Dependence[b,c]
305.90 Inhalant Abuse

### Inhalant-Induced Disorders

292.89 Inhalant Intoxication
292.81 Inhalant Intoxication Delirium
292.82 Inhalant-Induced Persisting Dementia
292.xx Inhalant-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Inhalant-Induced Mood Disorder[I]
292.89 Inhalant-Induced Anxiety Disorder[I]
292.9 Inhalant-Related Disorder NOS

## NICOTINE-RELATED DISORDERS

### Nicotine Use Disorder

305.1 Nicotine Dependence[a,b]

### Nicotine-Induced Disorder

292.0 Nicotine Withdrawal
292.9 Nicotine-Related Disorder NOS

## OPIOID-RELATED DISORDERS

### Opioid Use Disorders

304.00 Opioid Dependence[a,b,c,d]
305.50 Opioid Abuse

### Opioid-Induced Disorders

292.89 Opioid Intoxication
*Specify if*: With Perceptual Disturbances
292.0 Opioid Withdrawal
292.81 Opioid Intoxication Delirium
292.xx Opioid-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Opioid-Induced Mood Disorder[I]
292.89 Opioid-Induced Sexual Dysfunction[I]
292.85 Opioid-Induced Sleep Disorder[I,W]
292.9 Opioid-Related Disorder NOS

## PHENCYCLIDINE (OR PHENCYCLIDINE-LIKE)-RELATED DISORDERS

### Phencyclidine Use Disorders

304.60 Phencyclidine Dependence[b,c]
305.90 Phencyclidine Abuse

### Phencyclidine-Induced Disorders

292.89 Phencyclidine Intoxication
*Specify if*: With Perceptual Disturbances
292.81 Phencyclidine Intoxication Delirium
292.xx Phencyclidine-Induced Psychotic Disorder
.11 With Delusions[I]
.12 With Hallucinations[I]
292.84 Phencyclidine-Induced Mood Disorder[I]
292.89 Phencyclidine-Induced Anxiety Disorder[I]
292.9 Phencyclidine-Related Disorder NOS

## SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS

### Sedative, Hypnotic, or Anxiolytic Use Disorders

304.10 Sedative, Hypnotic, or Anxiolytic Dependence[a,b,c]
305.40 Sedative, Hypnotic, or Anxiolytic Abuse

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

292.89 Sedative, Hypnotic, or Anxiolytic Intoxication
292.0 Sedative, Hypnotic, or Anxiolytic Withdrawal
*Specify if*: With Perceptual Disturbances
292.81 Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
292.81 Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
292.82 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
292.83 Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Amnestic Disorder
292.xx Sedative-, Hypnotic-, or Anxiolytic-Induced Psychotic Disorder
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Sedative-, Hypnotic-, or Anxiolytic-Induced Mood Disorder[I,W]
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Anxiety Disorder[W]
292.89 Sedative-, Hypnotic-, or Anxiolytic-Induced Sexual Dysfunction[I]
292.85 Sedative-, Hypnotic-, or Anxiolytic-Induced Sleep Disorder[I,W]
292.9 Sedative-, Hypnotic-, or Anxiolytic-Related Disorder NOS

## POLYSUBSTANCE-RELATED DISORDER

304.80 Polysubstance Dependence[a,b,c,d]

## OTHER (OR UNKNOWN) SUBSTANCE-RELATED DISORDERS

### Other (or Unknown) Substance Use Disorders

304.90 Other (or Unknown) Substance Dependence[a,b,c,d]
305.90 Other (or Unknown) Substance Abuse

### Other (or Unknown) Substance-Induced Disorders

292.89 Other (or Unknown) Substance Intoxication
*Specify if*: With Perceptual Disturbances
292.0 Other (or Unknown) Substance Withdrawal
*Specify if*: With Perceptual Disturbances
292.81 Other (or Unknown) Substance-Induced Delirium

292.82 Other (or Unknown) Substance-Induced Persisting Dementia
292.83 Other (or Unknown) Substance-Induced Persisting Amnestic Disorder
292.xx Other (or Unknown) Substance-Induced Psychotic Disorder
.11 With Delusions[I,W]
.12 With Hallucinations[I,W]
292.84 Other (or Unknown) Substance-Induced Mood Disorder[I,W]
292.89 Other (or Unknown) Substance-Induced Anxiety Disorder[I,W]
292.89 Other (or Unknown) Substance-Induced Sexual Dysfunction[I]
292.85 Other (or Unknown) Substance-Induced Sleep Disorder[I,W]
292.9 Other (or Unknown) Substance-Related Disorder NOS

## Schizophrenia and Other Psychotic Disorders

295.xx Schizophrenia

*The following Classification of Longitudinal Course applies to all subtypes of Schizophrenia.*

Episodic With Interepisode Residual Symptoms (*specify if*: With Prominent Negative Symptoms)/ Episodic With No Interepisode Residual Symptoms/ Continuous (*specify if*: With Prominent Negative Symptoms)

Single Episode In Partial Remission (*specify if*: With Prominent Negative Symptoms)/Single Episode In Full Remission

Other or Unspecified Pattern
.30 Paranoid Type
.10 Disorganized Type
.20 Catatonic Type
.90 Undifferentiated Type
.60 Residual Type
295.40 Schizophreniform Disorder
*Specify if*: Without Good Prognostic Features/With Good Prognostic Features
295.70 Schizoaffective Disorder
*Specify type*: Bipolar Type/Depressive Type
297.1 Delusional Disorder
*Specify type*: Erotomanic Type/ Grandiose Type/Jealous Type/ Persecutory Type/Somatic Type/ Mixed Type/Unspecified Type
298.8 Brief Psychotic Disorder
*Specify if*: With Marked Stressor(s)/Without Marked Stressor(s)/With Postpartum Onset
297.3 Shared Psychotic Disorder
293.xx Psychotic Disorder Due to... [*Indicate the General Medical Condition*]
.81 With Delusions
.82 With Hallucinations
—.— Substance-Induced Psychotic Disorder (*refer to Substance-Related Disorders for substance-specific codes*)
*Specify if*: With Onset During Intoxication/ With Onset During Withdrawal
298.9 Psychotic Disorder NOS

## Mood Disorders

*Code current state of Major Depressive Disorder or Bipolar I Disorder in fifth digit*:

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

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

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

*The following specifiers apply to Mood Disorders as noted*:

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

### DEPRESSIVE DISORDERS

296.xx Major Depressive Disorder,
.2x Single Episode[a,b,c,d,e,f]
.3x Recurrent[a,b,c,d,e,f,g,h]
300.4 Dysthymic Disorder
*Specify if*: Early Onset/Late Onset
*Specify*: With Atypical Features
311 Depressive Disorder NOS

### BIPOLAR DISORDERS

296.xx Bipolar I Disorder,
.0x Single Manic Episode[a,c,f]