DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

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DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

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Contents

DSM-5 Classification xiii
Preface xli

Section I
DSM-5 Basics

Introduction 5
Use of the Manual 19
Cautionary Statement for Forensic Use of DSM-5 25

Section II
Diagnostic Criteria and Codes

Neurodevelopmental Disorders 31
Schizophrenia Spectrum and Other Psychotic Disorders 87
Bipolar and Related Disorders 123
Depressive Disorders 155
Anxiety Disorders. 189
Obsessive-Compulsive and Related Disorders 235
Trauma- and Stressor-Related Disorders 265
Dissociative Disorders 291
Somatic Symptom and Related Disorders 309
Feeding and Eating Disorders 329
Elimination Disorders 355
Sleep-Wake Disorders. 361
Sexual Dysfunctions 423
Gender Dysphoria 451

Disruptive, Impulse-Control, and Conduct Disorders 461
Substance-Related and Addictive Disorders 481
Neurocognitive Disorders. 591
Personality Disorders 645
Paraphilic Disorders 685
Other Mental Disorders 707
Medication-Induced Movement Disorders and Other Adverse Effects of Medication 709
Other Conditions That May Be a Focus of Clinical Attention . . 715

Section III
Emerging Measures and Models

Assessment Measures 733
Cultural Formulation 749
Alternative DSM-5 Model for Personality Disorders 761
Conditions for Further Study 783

Appendix

Highlights of Changes From DSM-IV to DSM-5 809
Glossary of Technical Terms 817
Glossary of Cultural Concepts of Distress 833
Alphabetical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM and ICD-10-CM) 839
Numerical Listing of DSM-5 Diagnoses and Codes (ICD-9-CM) 863
Numerical Listing of DSM-5 Diagnoses and Codes (ICD-10-CM) 877
DSM-5 Advisors and Other Contributors 897

Index 917

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DSM-5 Classification

Before each disorder name, ICD-9-CM codes are provided, followed by ICD-10-CM codes in parentheses. Blank lines indicate that either the ICD-9-CM or the ICD-10-CM code is not applicable. For some disorders, the code can be indicated only according to the subtype or specifier.

ICD-9-CM codes are to be used for coding purposes in the United States through September 30, 2014. ICD-10-CM codes are to be used starting October 1, 2014.

Following chapter titles and disorder names, page numbers for the corresponding text or criteria are included in parentheses.

Note for all mental disorders due to another medical condition: Indicate the name of the other medical condition in the name of the mental disorder due to [the medical condition]. The code and name for the other medical condition should be listed first immediately before the mental disorder due to the medical condition.

Neurodevelopmental Disorders (31)

Intellectual Disabilities (33)

___.__ (___.__)	Intellectual Disability (Intellectual Developmental Disorder) (33) *Specify* current severity:
317 (F70)	Mild
318.0 (F71)	Moderate
318.1 (F72)	Severe
318.2 (F73)	Profound
315.8 (F88)	Global Developmental Delay (41)
319 (F79)	Unspecified Intellectual Disability (Intellectual Developmental Disorder) (41)

Communication Disorders (41)

315.32 (F80.2)	Language Disorder (42)
315.39 (F80.0)	Speech Sound Disorder (44)
315.35 (F80.81)	Childhood-Onset Fluency Disorder (Stuttering) (45) **Note:** Later-onset cases are diagnosed as 307.0 (F98.5) adult-onset fluency disorder.
315.39 (F80.89)	Social (Pragmatic) Communication Disorder (47)
307.9 (F80.9)	Unspecified Communication Disorder (49)

Autism Spectrum Disorder (50)

299.00 (F84.0) Autism Spectrum Disorder (50)
Specify if: Associated with a known medical or genetic condition or environmental factor; Associated with another neurodevelopmental, mental, or behavioral disorder
Specify current severity for Criterion A and Criterion B: Requiring very substantial support, Requiring substantial support, Requiring support
Specify if: With or without accompanying intellectual impairment, With or without accompanying language impairment, With catatonia (use additional code 293.89 [F06.1])

Attention-Deficit/Hyperactivity Disorder (59)

___.__ (___.__) Attention-Deficit/Hyperactivity Disorder (59)
Specify whether:
314.01 (F90.2) Combined presentation
314.00 (F90.0) Predominantly inattentive presentation
314.01 (F90.1) Predominantly hyperactive/impulsive presentation
Specify if: In partial remission
Specify current severity: Mild, Moderate, Severe

314.01 (F90.8) Other Specified Attention-Deficit/Hyperactivity Disorder (65)

314.01 (F90.9) Unspecified Attention-Deficit/Hyperactivity Disorder (66)

Specific Learning Disorder (66)

___.__ (___.__) Specific Learning Disorder (66)
Specify if:
315.00 (F81.0) With impairment in reading (*specify* if with word reading accuracy, reading rate or fluency, reading comprehension)
315.2 (F81.81) With impairment in written expression (*specify* if with spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression)
315.1 (F81.2) With impairment in mathematics (*specify* if with number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning)
Specify current severity: Mild, Moderate, Severe

Motor Disorders (74)

315.4 (F82) Developmental Coordination Disorder (74)

307.3 (F98.4) Stereotypic Movement Disorder (77)
Specify if: With self-injurious behavior, Without self-injurious behavior
Specify if: Associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor
Specify current severity: Mild, Moderate, Severe

Tic Disorders

307.23 (F95.2) Tourette's Disorder (81)

307.22 (F95.1) Persistent (Chronic) Motor or Vocal Tic Disorder (81)
Specify if: With motor tics only, With vocal tics only

307.21 (F95.0) Provisional Tic Disorder (81)

307.20 (F95.8) Other Specified Tic Disorder (85)

307.20 (F95.9) Unspecified Tic Disorder (85)

Other Neurodevelopmental Disorders (86)

315.8 (F88) Other Specified Neurodevelopmental Disorder (86)

315.9 (F89) Unspecified Neurodevelopmental Disorder (86)

Schizophrenia Spectrum and Other Psychotic Disorders (87)

The following specifiers apply to Schizophrenia Spectrum and Other Psychotic Disorders where indicated:

[a] *Specify* if: The following course specifiers are only to be used after a 1-year duration of the disorder: First episode, currently in acute episode; First episode, currently in partial remission; First episode, currently in full remission; Multiple episodes, currently in acute episode; Multiple episodes, currently in partial remission; Multiple episodes, currently in full remission; Continuous; Unspecified

[b] *Specify* if: With catatonia (use additional code 293.89 [F06.1])

[c] *Specify* current severity of delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania symptoms

301.22 (F21) Schizotypal (Personality) Disorder (90)

297.1 (F22) Delusional Disorder[a, c] (90)
Specify whether: Erotomanic type, Grandiose type, Jealous type, Persecutory type, Somatic type, Mixed type, Unspecified type
Specify if: With bizarre content

298.8 (F23) Brief Psychotic Disorder[b, c] (94)
Specify if: With marked stressor(s), Without marked stressor(s), With postpartum onset

295.40 (F20.81) Schizophreniform Disorder[b, c] (96)
Specify if: With good prognostic features, Without good prognostic features

295.90 (F20.9) Schizophrenia[a, b, c] (99)

___.__ (___.__) Schizoaffective Disorder[a, b, c] (105)
Specify whether:

295.70 (F25.0) Bipolar type

295.70 (F25.1) Depressive type

___.__ (___.__) Substance/Medication-Induced Psychotic Disorder[c] (110)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal

___.__ (___.__) Psychotic Disorder Due to Another Medical Condition[c] (115)
Specify whether:

293.81 (F06.2) With delusions

293.82 (F06.0) With hallucinations

293.89 (F06.1) Catatonia Associated With Another Mental Disorder (Catatonia Specifier) (119)

293.89 (F06.1) Catatonic Disorder Due to Another Medical Condition (120)

293.89 (F06.1) Unspecified Catatonia (121)
Note: Code first **781.99 (R29.818)** other symptoms involving nervous and musculoskeletal systems.

298.8 (F28) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (122)

298.9 (F29) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (122)

Bipolar and Related Disorders (123)

The following specifiers apply to Bipolar and Related Disorders where indicated:
[a]*Specify:* With anxious distress (*specify* current severity: mild, moderate, moderate-severe, severe); With mixed features; With rapid cycling; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia (use additional code 293.89 [F06.1]); With peripartum onset; With seasonal pattern

___.__ (___.__) Bipolar I Disorder[a] (123)
___.__ (___.__) Current or most recent episode manic
296.41 (F31.11) Mild
296.42 (F31.12) Moderate
296.43 (F31.13) Severe
296.44 (F31.2) With psychotic features
296.45 (F31.73) In partial remission
296.46 (F31.74) In full remission
296.40 (F31.9) Unspecified
296.40 (F31.0) Current or most recent episode hypomanic
296.45 (F31.71) In partial remission
296.46 (F31.72) In full remission
296.40 (F31.9) Unspecified
___.__ (___.__) Current or most recent episode depressed
296.51 (F31.31) Mild
296.52 (F31.32) Moderate
296.53 (F31.4) Severe
296.54 (F31.5) With psychotic features
296.55 (F31.75) In partial remission
296.56 (F31.76) In full remission
296.50 (F31.9) Unspecified
296.7 (F31.9) Current or most recent episode unspecified

296.89 (F31.81) Bipolar II Disorder[a] (132)
Specify current or most recent episode: Hypomanic, Depressed
Specify course if full criteria for a mood episode are not currently met: In partial remission, In full remission
Specify severity if full criteria for a mood episode are currently met: Mild, Moderate, Severe

301.13 (F34.0) Cyclothymic Disorder (139)
Specify if: With anxious distress

___.__ (___.__) Substance/Medication-Induced Bipolar and Related Disorder (142)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal

293.83 (___.__) Bipolar and Related Disorder Due to Another Medical Condition (145)
Specify if:
(F06.33) With manic features
(F06.33) With manic- or hypomanic-like episode
(F06.34) With mixed features

296.89 (F31.89) Other Specified Bipolar and Related Disorder (148)

296.80 (F31.9) Unspecified Bipolar and Related Disorder (149)

Depressive Disorders (155)

The following specifiers apply to Depressive Disorders where indicated:
[a]*Specify:* With anxious distress (*specify* current severity: mild, moderate, moderate-severe, severe); With mixed features; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia (use additional code 293.89 [F06.1]); With peripartum onset; With seasonal pattern

296.99 (F34.8) Disruptive Mood Dysregulation Disorder (156)

___.__ (___.__) Major Depressive Disorder[a] (160)
___.__ (___.__) Single episode
296.21 (F32.0) Mild
296.22 (F32.1) Moderate
296.23 (F32.2) Severe
296.24 (F32.3) With psychotic features
296.25 (F32.4) In partial remission
296.26 (F32.5) In full remission
296.20 (F32.9) Unspecified
___.__ (___.__) Recurrent episode
296.31 (F33.0) Mild
296.32 (F33.1) Moderate
296.33 (F33.2) Severe
296.34 (F33.3) With psychotic features
296.35 (F33.41) In partial remission
296.36 (F33.42) In full remission
296.30 (F33.9) Unspecified

300.4 (F34.1) Persistent Depressive Disorder (Dysthymia)[a] (168)
Specify if: In partial remission, In full remission
Specify if: Early onset, Late onset
Specify if: With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, with current

episode; With intermittent major depressive episodes, without current episode
Specify current severity: Mild, Moderate, Severe

625.4 (N94.3) Premenstrual Dysphoric Disorder (171)

___.__ (___.__) Substance/Medication-Induced Depressive Disorder (175)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal

293.83 (___.__) Depressive Disorder Due to Another Medical Condition (180)
Specify if:
(F06.31) With depressive features
(F06.32) With major depressive-like episode
(F06.34) With mixed features

311 (F32.8) Other Specified Depressive Disorder (183)

311 (F32.9) Unspecified Depressive Disorder (184)

Anxiety Disorders (189)

309.21 (F93.0) Separation Anxiety Disorder (190)

313.23 (F94.0) Selective Mutism (195)

300.29 (___.__) Specific Phobia (197)
Specify if:
(F40.218) Animal
(F40.228) Natural environment
(___.__) Blood-injection-injury
(F40.230) Fear of blood
(F40.231) Fear of injections and transfusions
(F40.232) Fear of other medical care
(F40.233) Fear of injury
(F40.248) Situational
(F40.298) Other

300.23 (F40.10) Social Anxiety Disorder (Social Phobia) (202)
Specify if: Performance only

300.01 (F41.0) Panic Disorder (208)

___.__ (___.__) Panic Attack Specifier (214)

300.22 (F40.00) Agoraphobia (217)

300.02 (F41.1) Generalized Anxiety Disorder (222)

___.__ (___.__) Substance/Medication-Induced Anxiety Disorder (226)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

293.84 (F06.4) Anxiety Disorder Due to Another Medical Condition (230)

300.09 (F41.8) Other Specified Anxiety Disorder (233)

300.00 (F41.9) Unspecified Anxiety Disorder (233)

Obsessive-Compulsive and Related Disorders (235)

The following specifier applies to Obsessive-Compulsive and Related Disorders where indicated:
[a]*Specify* if: With good or fair insight, With poor insight, With absent insight/delusional beliefs

300.3 (F42) Obsessive-Compulsive Disorder[a] (237)
Specify if: Tic-related

300.7 (F45.22) Body Dysmorphic Disorder[a] (242)
Specify if: With muscle dysmorphia

300.3 (F42) Hoarding Disorder[a] (247)
Specify if: With excessive acquisition

312.39 (F63.3) Trichotillomania (Hair-Pulling Disorder) (251)

698.4 (L98.1) Excoriation (Skin-Picking) Disorder (254)

___.__ (___.__) Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (257)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

294.8 (F06.8) Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (260)
Specify if: With obsessive-compulsive disorder–like symptoms, With appearance preoccupations, With hoarding symptoms, With hair-pulling symptoms, With skin-picking symptoms

300.3 (F42) Other Specified Obsessive-Compulsive and Related Disorder (263)

300.3 (F42) Unspecified Obsessive-Compulsive and Related Disorder (264)

Trauma- and Stressor-Related Disorders (265)

313.89 (F94.1) Reactive Attachment Disorder (265)
Specify if: Persistent
Specify current severity: Severe

313.89 (F94.2) Disinhibited Social Engagement Disorder (268)
Specify if: Persistent
Specify current severity: Severe

309.81 (F43.10) Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger) (271)
Specify whether: With dissociative symptoms
Specify if: With delayed expression

308.3 (F43.0) Acute Stress Disorder (280)

___.__ (___.__) Adjustment Disorders (286)
Specify whether:
309.0 (F43.21) With depressed mood
309.24 (F43.22) With anxiety
309.28 (F43.23) With mixed anxiety and depressed mood
309.3 (F43.24) With disturbance of conduct
309.4 (F43.25) With mixed disturbance of emotions and conduct
309.9 (F43.20) Unspecified
309.89 (F43.8) Other Specified Trauma- and Stressor-Related Disorder (289)
309.9 (F43.9) Unspecified Trauma- and Stressor-Related Disorder (290)

Dissociative Disorders (291)

300.14 (F44.81) Dissociative Identity Disorder (292)
300.12 (F44.0) Dissociative Amnesia (298)
Specify if:
300.13 (F44.1) With dissociative fugue
300.6 (F48.1) Depersonalization/Derealization Disorder (302)
300.15 (F44.89) Other Specified Dissociative Disorder (306)
300.15 (F44.9) Unspecified Dissociative Disorder (307)

Somatic Symptom and Related Disorders (309)

300.82 (F45.1) Somatic Symptom Disorder (311)
Specify if: With predominant pain
Specify if: Persistent
Specify current severity: Mild, Moderate, Severe
300.7 (F45.21) Illness Anxiety Disorder (315)
Specify whether: Care seeking type, Care avoidant type
300.11 (___.__) Conversion Disorder (Functional Neurological Symptom Disorder) (318)
Specify symptom type:
(F44.4) With weakness or paralysis
(F44.4) With abnormal movement
(F44.4) With swallowing symptoms
(F44.4) With speech symptom
(F44.5) With attacks or seizures
(F44.6) With anesthesia or sensory loss
(F44.6) With special sensory symptom
(F44.7) With mixed symptoms
Specify if: Acute episode, Persistent
Specify if: With psychological stressor (specify stressor), Without psychological stressor

316 (F54) Psychological Factors Affecting Other Medical Conditions (322)
Specify current severity: Mild, Moderate, Severe, Extreme

300.19 (F68.10) Factitious Disorder (includes Factitious Disorder Imposed on Self, Factitious Disorder Imposed on Another) (324)
Specify Single episode, Recurrent episodes

300.89 (F45.8) Other Specified Somatic Symptom and Related Disorder (327)

300.82 (F45.9) Unspecified Somatic Symptom and Related Disorder (327)

Feeding and Eating Disorders (329)

The following specifiers apply to Feeding and Eating Disorders where indicated:
[a]*Specify* if: In remission
[b]*Specify* if: In partial remission, In full remission
[c]*Specify* current severity: Mild, Moderate, Severe, Extreme

307.52 (___.__) Pica[a] (329)
(F98.3) In children
(F50.8) In adults

307.53 (F98.21) Rumination Disorder[a] (332)

307.59 (F50.8) Avoidant/Restrictive Food Intake Disorder[a] (334)

307.1 (___.__) Anorexia Nervosa[b, c] (338)
Specify whether:
(F50.01) Restricting type
(F50.02) Binge-eating/purging type

307.51 (F50.2) Bulimia Nervosa[b, c] (345)

307.51 (F50.8) Binge-Eating Disorder[b, c] (350)

307.59 (F50.8) Other Specified Feeding or Eating Disorder (353)

307.50 (F50.9) Unspecified Feeding or Eating Disorder (354)

Elimination Disorders (355)

307.6 (F98.0) Enuresis (355)
Specify whether: Nocturnal only, Diurnal only, Nocturnal and diurnal

307.7 (F98.1) Encopresis (357)
Specify whether: With constipation and overflow incontinence, Without constipation and overflow incontinence

___.__ (___.__) Other Specified Elimination Disorder (359)
788.39 (N39.498) With urinary symptoms
787.60 (R15.9) With fecal symptoms

___.__ (___.__) Unspecified Elimination Disorder (360)
788.30 (R32) With urinary symptoms
787.60 (R15.9) With fecal symptoms

Sleep-Wake Disorders (361)

The following specifiers apply to Sleep-Wake Disorders where indicated:
[a]*Specify* if: Episodic, Persistent, Recurrent
[b]*Specify* if: Acute, Subacute, Persistent
[c]*Specify* current severity: Mild, Moderate, Severe

307.42 (F51.01) Insomnia Disorder[a] (362)
Specify if: With non–sleep disorder mental comorbidity, With other medical comorbidity, With other sleep disorder

307.44 (F51.11) Hypersomnolence Disorder[b, c] (368)
Specify if: With mental disorder, With medical condition, With another sleep disorder

___.__ (___.__) Narcolepsy[c] (372)
Specify whether:

347.00 (G47.419) Narcolepsy without cataplexy but with hypocretin deficiency

347.01 (G47.411) Narcolepsy with cataplexy but without hypocretin deficiency

347.00 (G47.419) Autosomal dominant cerebellar ataxia, deafness, and narcolepsy

347.00 (G47.419) Autosomal dominant narcolepsy, obesity, and type 2 diabetes

347.10 (G47.429) Narcolepsy secondary to another medical condition

Breathing-Related Sleep Disorders (378)

327.23 (G47.33) Obstructive Sleep Apnea Hypopnea[c] (378)

___.__ (___.__) Central Sleep Apnea (383)
Specify whether:

327.21 (G47.31) Idiopathic central sleep apnea

786.04 (R06.3) Cheyne-Stokes breathing

780.57 (G47.37) Central sleep apnea comorbid with opioid use
Note: First code opioid use disorder, if present.
Specify current severity

___.__ (___.__) Sleep-Related Hypoventilation (387)
Specify whether:

327.24 (G47.34) Idiopathic hypoventilation

327.25 (G47.35) Congenital central alveolar hypoventilation

327.26 (G47.36) Comorbid sleep-related hypoventilation
Specify current severity

___.__ (___.__) Circadian Rhythm Sleep-Wake Disorders[a] (390)
Specify whether:

307.45 (G47.21) Delayed sleep phase type (391)
Specify if: Familial, Overlapping with non-24-hour sleep-wake type

307.45 (G47.22) Advanced sleep phase type (393)
Specify if: Familial

307.45 (G47.23) Irregular sleep-wake type (394)

307.45 (G47.24) Non-24-hour sleep-wake type (396)

307.45 (G47.26) Shift work type (397)

307.45 (G47.20) Unspecified type

Parasomnias (399)

___.__ (__.__) Non–Rapid Eye Movement Sleep Arousal Disorders (399)
Specify whether:

307.46 (F51.3) Sleepwalking type
Specify if: With sleep-related eating, With sleep-related sexual behavior (sexsomnia)

307.46 (F51.4) Sleep terror type

307.47 (F51.5) Nightmare Disorder[b, c] (404)
Specify if: During sleep onset
Specify if: With associated non–sleep disorder, With associated other medical condition, With associated other sleep disorder

327.42 (G47.52) Rapid Eye Movement Sleep Behavior Disorder (407)

333.94 (G25.81) Restless Legs Syndrome (410)

___.__ (___.__) Substance/Medication-Induced Sleep Disorder (413)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify whether: Insomnia type, Daytime sleepiness type, Parasomnia type, Mixed type
Specify if: With onset during intoxication, With onset during discontinuation/withdrawal

780.52 (G47.09) Other Specified Insomnia Disorder (420)

780.52 (G47.00) Unspecified Insomnia Disorder (420)

780.54 (G47.19) Other Specified Hypersomnolence Disorder (421)

780.54 (G47.10) Unspecified Hypersomnolence Disorder (421)

780.59 (G47.8) Other Specified Sleep-Wake Disorder (421)

780.59 (G47.9) Unspecified Sleep-Wake Disorder (422)

Sexual Dysfunctions (423)

The following specifiers apply to Sexual Dysfunctions where indicated:
[a]*Specify* whether: Lifelong, Acquired
[b]*Specify* whether: Generalized, Situational
[c]*Specify* current severity: Mild, Moderate, Severe

302.74 (F52.32) Delayed Ejaculation[a, b, c] (424)

302.72 (F52.21) Erectile Disorder[a, b, c] (426)

302.73 (F52.31) Female Orgasmic Disorder[a, b, c] (429)
Specify if: Never experienced an orgasm under any situation

302.72 (F52.22) Female Sexual Interest/Arousal Disorder[a, b, c] (433)

302.76 (F52.6) Genito-Pelvic Pain/Penetration Disorder[a, c] (437)

302.71 (F52.0) Male Hypoactive Sexual Desire Disorder[a, b, c] (440)

302.75 (F52.4) Premature (Early) Ejaculation[a, b, c] (443)

___.__ (___.__) Substance/Medication-Induced Sexual Dysfunction[c] (446)
Note: See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: With onset during intoxication, With onset during withdrawal, With onset after medication use

302.79 (F52.8) Other Specified Sexual Dysfunction (450)

302.70 (F52.9) Unspecified Sexual Dysfunction (450)

Gender Dysphoria (451)

___.__ (__.__) Gender Dysphoria (452)

302.6 (F64.2) Gender Dysphoria in Children
Specify if: With a disorder of sex development

302.85 (F64.1) Gender Dysphoria in Adolescents and Adults
Specify if: With a disorder of sex development
Specify if: Posttransition
Note: Code the disorder of sex development if present, in addition to gender dysphoria.

302.6 (F64.8) Other Specified Gender Dysphoria (459)

302.6 (F64.9) Unspecified Gender Dysphoria (459)

Disruptive, Impulse-Control, and Conduct Disorders (461)

313.81 (F91.3) Oppositional Defiant Disorder (462)
Specify current severity: Mild, Moderate, Severe

312.34 (F63.81) Intermittent Explosive Disorder (466)

___.__ (__.__) Conduct Disorder (469)
Specify whether:

312.81 (F91.1) Childhood-onset type

312.82 (F91.2) Adolescent-onset type

312.89 (F91.9) Unspecified onset
Specify if: With limited prosocial emotions
Specify current severity: Mild, Moderate, Severe

301.7 (F60.2) Antisocial Personality Disorder (476)

312.33 (F63.1) Pyromania (476)

312.32 (F63.2) Kleptomania (478)

312.89 (F91.8) Other Specified Disruptive, Impulse-Control, and Conduct Disorder (479)

312.9 (F91.9) Unspecified Disruptive, Impulse-Control, and Conduct Disorder (480)

Substance-Related and Addictive Disorders (481)

The following specifiers and note apply to Substance-Related and Addictive Disorders where indicated:
[a]*Specify* if: In early remission, In sustained remission
[b]*Specify* if: In a controlled environment
[c]*Specify* if: With perceptual disturbances
[d]The ICD-10-CM code indicates the comorbid presence of a moderate or severe substance use disorder, which must be present in order to apply the code for substance withdrawal.

Substance-Related Disorders (483)

Alcohol-Related Disorders (490)

___.__	(___.__)	Alcohol Use Disorder[a, b] (490)
		Specify current severity:
305.00	**(F10.10)**	Mild
303.90	**(F10.20)**	Moderate
303.90	**(F10.20)**	Severe
303.00	(___.__)	Alcohol Intoxication (497)
	(F10.129)	With use disorder, mild
	(F10.229)	With use disorder, moderate or severe
	(F10.929)	Without use disorder
291.81	(___.__)	Alcohol Withdrawal[c, d] (499)
	(F10.239)	Without perceptual disturbances
	(F10.232)	With perceptual disturbances
___.__	(___.__)	Other Alcohol-Induced Disorders (502)
291.9	**(F10.99)**	Unspecified Alcohol-Related Disorder (503)

Caffeine-Related Disorders (503)

305.90	**(F15.929)**	Caffeine Intoxication (503)
292.0	**(F15.93)**	Caffeine Withdrawal (506)
___.__	(___.__)	Other Caffeine-Induced Disorders (508)
292.9	**(F15.99)**	Unspecified Caffeine-Related Disorder (509)

Cannabis-Related Disorders (509)

___.__	(___.__)	Cannabis Use Disorder[a, b] (509)
		Specify current severity:
305.20	**(F12.10)**	Mild
304.30	**(F12.20)**	Moderate
304.30	**(F12.20)**	Severe

292.89 **(___.__)** Cannabis Intoxication[c] (516)
Without perceptual disturbances
(F12.129) With use disorder, mild
(F12.229) With use disorder, moderate or severe
(F12.929) Without use disorder
With perceptual disturbances
(F12.122) With use disorder, mild
(F12.222) With use disorder, moderate or severe
(F12.922) Without use disorder

292.0 **(F12.288)** Cannabis Withdrawal[d] (517)

___.__ **(___.__)** Other Cannabis-Induced Disorders (519)

292.9 **(F12.99)** Unspecified Cannabis-Related Disorder (519)

Hallucinogen-Related Disorders (520)

___.__ **(___.__)** Phencyclidine Use Disorder[a, b] (520)
Specify current severity:
305.90 **(F16.10)** Mild
304.60 **(F16.20)** Moderate
304.60 **(F16.20)** Severe

___.__ **(___.__)** Other Hallucinogen Use Disorder[a, b] (523)
Specify the particular hallucinogen
Specify current severity:
305.30 **(F16.10)** Mild
304.50 **(F16.20)** Moderate
304.50 **(F16.20)** Severe

292.89 **(___.__)** Phencyclidine Intoxication (527)
(F16.129) With use disorder, mild
(F16.229) With use disorder, moderate or severe
(F16.929) Without use disorder

292.89 **(___.__)** Other Hallucinogen Intoxication (529)
(F16.129) With use disorder, mild
(F16.229) With use disorder, moderate or severe
(F16.929) Without use disorder

292.89 **(F16.983)** Hallucinogen Persisting Perception Disorder (531)

___.__ **(___.__)** Other Phencyclidine-Induced Disorders (532)

___.__ **(___.__)** Other Hallucinogen-Induced Disorders (532)

292.9 **(F16.99)** Unspecified Phencyclidine-Related Disorder (533)

292.9 **(F16.99)** Unspecified Hallucinogen-Related Disorder (533)

Inhalant-Related Disorders (533)

___.__ **(___.__)** Inhalant Use Disorder[a, b] (533)
Specify the particular inhalant
Specify current severity:
305.90 **(F18.10)** Mild

304.60 (F18.20) Moderate
304.60 (F18.20) Severe

292.89 (___.__) Inhalant Intoxication (538)
(F18.129) With use disorder, mild
(F18.229) With use disorder, moderate or severe
(F18.929) Without use disorder

___.__ (___.__) Other Inhalant-Induced Disorders (540)

292.9 (F18.99) Unspecified Inhalant-Related Disorder (540)

Opioid-Related Disorders (540)

___.__ (___.__) Opioid Use Disorder[a] (541)
Specify if: On maintenance therapy, In a controlled environment
Specify current severity:
305.50 (F11.10) Mild
304.00 (F11.20) Moderate
304.00 (F11.20) Severe

292.89 (___.__) Opioid Intoxication[c] (546)
Without perceptual disturbances
(F11.129) With use disorder, mild
(F11.229) With use disorder, moderate or severe
(F11.929) Without use disorder
With perceptual disturbances
(F11.122) With use disorder, mild
(F11.222) With use disorder, moderate or severe
(F11.922) Without use disorder

292.0 (F11.23) Opioid Withdrawal[d] (547)

___.__ (___.__) Other Opioid-Induced Disorders (549)

292.9 (F11.99) Unspecified Opioid-Related Disorder (550)

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders (550)

___.__ (___.__) Sedative, Hypnotic, or Anxiolytic Use Disorder[a, b] (550)
Specify current severity:
305.40 (F13.10) Mild
304.10 (F13.20) Moderate
304.10 (F13.20) Severe

292.89 (___.__) Sedative, Hypnotic, or Anxiolytic Intoxication (556)
(F13.129) With use disorder, mild
(F13.229) With use disorder, moderate or severe
(F13.929) Without use disorder

292.0 (___.__) Sedative, Hypnotic, or Anxiolytic Withdrawal[c, d] (557)
(F13.239) Without perceptual disturbances
(F13.232) With perceptual disturbances

___.__ (___.__) Other Sedative-, Hypnotic-, or Anxiolytic-Induced Disorders (560)

292.9 (F13.99) Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder (560)

Stimulant-Related Disorders (561)

___.__ (___.__) Stimulant Use Disorder[a, b] (561)
Specify current severity:
___.__ (___.__) Mild
305.70 (F15.10) Amphetamine-type substance
305.60 (F14.10) Cocaine
305.70 (F15.10) Other or unspecified stimulant
___.__ (___.__) Moderate
304.40 (F15.20) Amphetamine-type substance
304.20 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant
___.__ (___.__) Severe
304.40 (F15.20) Amphetamine-type substance
304.20 (F14.20) Cocaine
304.40 (F15.20) Other or unspecified stimulant

292.89 (___.__) Stimulant Intoxication[c] (567)
Specify the specific intoxicant
292.89 (___.__) Amphetamine or other stimulant, Without perceptual disturbances
(F15.129) With use disorder, mild
(F15.229) With use disorder, moderate or severe
(F15.929) Without use disorder
292.89 (___.__) Cocaine, Without perceptual disturbances
(F14.129) With use disorder, mild
(F14.229) With use disorder, moderate or severe
(F14.929) Without use disorder
292.89 (___.__) Amphetamine or other stimulant, With perceptual disturbances
(F15.122) With use disorder, mild
(F15.222) With use disorder, moderate or severe
(F15.922) Without use disorder
292.89 (___.__) Cocaine, With perceptual disturbances
(F14.122) With use disorder, mild
(F14.222) With use disorder, moderate or severe
(F14.922) Without use disorder

292.0 (___.__) Stimulant Withdrawal[d] (569)
Specify the specific substance causing the withdrawal syndrome
(F15.23) Amphetamine or other stimulant
(F14.23) Cocaine

___.__ (___.__) Other Stimulant-Induced Disorders (570)

292.9 (___.__) Unspecified Stimulant-Related Disorder (570)
(F15.99) Amphetamine or other stimulant
(F14.99) Cocaine

Tobacco-Related Disorders (571)

___.__ (___.__) Tobacco Use Disorder[a] (571)
Specify if: On maintenance therapy, In a controlled environment
Specify current severity:
305.1 **(Z72.0)** Mild
305.1 **(F17.200)** Moderate
305.1 **(F17.200)** Severe

292.0 **(F17.203)** Tobacco Withdrawal[d] (575)

___.__ (___.__) Other Tobacco-Induced Disorders (576)

292.9 **(F17.209)** Unspecified Tobacco-Related Disorder (577)

Other (or Unknown) Substance–Related Disorders (577)

___._ (___.__) Other (or Unknown) Substance Use Disorder[a, b] (577)
Specify current severity:
305.90 **(F19.10)** Mild
304.90 **(F19.20)** Moderate
304.90 **(F19.20)** Severe

292.89 (___.__) Other (or Unknown) Substance Intoxication (581)
(F19.129) With use disorder, mild
(F19.229) With use disorder, moderate or severe
(F19.929) Without use disorder

292.0 **(F19.239)** Other (or Unknown) Substance Withdrawal[d] (583)

___.__ (___.__) Other (or Unknown) Substance–Induced Disorders (584)

292.9 **(F19.99)** Unspecified Other (or Unknown) Substance–Related Disorder (585)

Non-Substance-Related Disorders (585)

312.31 **(F63.0)** Gambling Disorder[a] (585)
Specify if: Episodic, Persistent
Specify current severity: Mild, Moderate, Severe

Neurocognitive Disorders (591)

___.__ (___.__) Delirium (596)
[a]**Note:** See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify whether:
___.__ (___.__) Substance intoxication delirium[a]
___.__ (___.__) Substance withdrawal delirium[a]
292.81 (___.__) Medication-induced delirium[a]
293.0 **(F05)** Delirium due to another medical condition

293.0 (F05) Delirium due to multiple etiologies
Specify if: Acute, Persistent
Specify if: Hyperactive, Hypoactive, Mixed level of activity

780.09 (R41.0) Other Specified Delirium (602)

780.09 (R41.0) Unspecified Delirium (602)

Major and Mild Neurocognitive Disorders (602)

Specify whether due to: Alzheimer's disease, Frontotemporal lobar degeneration, Lewy body disease, Vascular disease, Traumatic brain injury, Substance/medication use, HIV infection, Prion disease, Parkinson's disease, Huntington's disease, Another medical condition, Multiple etiologies, Unspecified

[a]*Specify* Without behavioral disturbance, With behavioral disturbance. *For possible major neurocognitive disorder and for mild neurocognitive disorder, behavioral disturbance cannot be coded but should still be indicated in writing.*

[b]*Specify* current severity: Mild, Moderate, Severe. *This specifier applies only to major neurocognitive disorders (including probable and possible).*

Note: As indicated for each subtype, an additional medical code is needed for probable major neurocognitive disorder or major neurocognitive disorder. An additional medical code should *not* be used for possible major neurocognitive disorder or mild neurocognitive disorder.

Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease (611)

___.__ (___.__) Probable Major Neurocognitive Disorder Due to Alzheimer's Disease[b]
Note: Code first **331.0 (G30.9)** Alzheimer's disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.9 (G31.9) Possible Major Neurocognitive Disorder Due to Alzheimer's Disease[a, b]

331.83 (G31.84) Mild Neurocognitive Disorder Due to Alzheimer's Disease[a]

Major or Mild Frontotemporal Neurocognitive Disorder (614)

___.__ (___.__) Probable Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration[b]
Note: Code first **331.19 (G31.09)** frontotemporal disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.9 (G31.9) Possible Major Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration[a, b]

331.83 (G31.84) Mild Neurocognitive Disorder Due to Frontotemporal Lobar Degeneration[a]

Major or Mild Neurocognitive Disorder With Lewy Bodies (618)

___.__ (___.__) Probable Major Neurocognitive Disorder With Lewy Bodies[b]
Note: Code first **331.82 (G31.83)** Lewy body disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.9 (G31.9) Possible Major Neurocognitive Disorder With Lewy Bodies[a, b]

331.83 (G31.84) Mild Neurocognitive Disorder With Lewy Bodies[a]

Major or Mild Vascular Neurocognitive Disorder (621)

___.__ (___.__) Probable Major Vascular Neurocognitive Disorder[b]
Note: No additional medical code for vascular disease.

290.40 (F01.51) With behavioral disturbance

290.40 (F01.50) Without behavioral disturbance

331.9 (G31.9) Possible Major Vascular Neurocognitive Disorder[a, b]

331.83 (G31.84) Mild Vascular Neurocognitive Disorder[a]

Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury (624)

___.__ (___.__) Major Neurocognitive Disorder Due to Traumatic Brain Injury[b]
Note: For ICD-9-CM, code first **907.0** late effect of intracranial injury without skull fracture. For ICD-10-CM, code first **S06.2X9S** diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to Traumatic Brain Injury[a]

Substance/Medication-Induced Major or Mild Neurocognitive Disorder[a] (627)
Note: No additional medical code. See the criteria set and corresponding recording procedures for substance-specific codes and ICD-9-CM and ICD-10-CM coding.
Specify if: Persistent

Major or Mild Neurocognitive Disorder Due to HIV Infection (632)

___.__ (___.__) Major Neurocognitive Disorder Due to HIV Infection[b]
Note: Code first **042 (B20)** HIV infection.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to HIV Infection[a]

Major or Mild Neurocognitive Disorder Due to Prion Disease (634)

___.__ (___.__) Major Neurocognitive Disorder Due to Prion Disease[b]
Note: Code first **046.79 (A81.9)** prion disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to Prion Disease[a]

Major or Mild Neurocognitive Disorder Due to Parkinson's Disease (636)

___.__ (___.__) Major Neurocognitive Disorder Probably Due to Parkinson's Disease[b]
Note: Code first **332.0 (G20)** Parkinson's disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.9 (G31.9) Major Neurocognitive Disorder Possibly Due to Parkinson's Disease[a, b]

331.83 (G31.84) Mild Neurocognitive Disorder Due to Parkinson's Disease[a]

Major or Mild Neurocognitive Disorder Due to Huntington's Disease (638)

___.__ (___.__) Major Neurocognitive Disorder Due to Huntington's Disease[b]
Note: Code first **333.4 (G10)** Huntington's disease.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to Huntington's Disease[a]

Major or Mild Neurocognitive Disorder Due to Another Medical Condition (641)

___.__ (___.__) Major Neurocognitive Disorder Due to Another Medical Condition[b]
Note: Code first the other medical condition.

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to Another Medical Condition[a]

Major or Mild Neurocognitive Disorder Due to Multiple Etiologies (642)

___.__ (___.__) Major Neurocognitive Disorder Due to Multiple Etiologies[b]
Note: Code first all the etiological medical conditions (with the exception of vascular disease).

294.11 (F02.81) With behavioral disturbance

294.10 (F02.80) Without behavioral disturbance

331.83 (G31.84) Mild Neurocognitive Disorder Due to Multiple Etiologies[a]

Unspecified Neurocognitive Disorder (643)

799.59 (R41.9) Unspecified Neurocognitive Disorder[a]

Personality Disorders (645)

Cluster A Personality Disorders

301.0 (F60.0) Paranoid Personality Disorder (649)

301.20 (F60.1) Schizoid Personality Disorder (652)

301.22 (F21) Schizotypal Personality Disorder (655)

Cluster B Personality Disorders

301.7 (F60.2) Antisocial Personality Disorder (659)

301.83 (F60.3) Borderline Personality Disorder (663)

301.50 (F60.4) Histrionic Personality Disorder (667)

301.81 (F60.81) Narcissistic Personality Disorder (669)

Cluster C Personality Disorders

301.82 (F60.6) Avoidant Personality Disorder (672)

301.6 (F60.7) Dependent Personality Disorder (675)

301.4 (F60.5) Obsessive-Compulsive Personality Disorder (678)

Other Personality Disorders

310.1 (F07.0) Personality Change Due to Another Medical Condition (682)
Specify whether: Labile type, Disinhibited type, Aggressive type, Apathetic type, Paranoid type, Other type, Combined type, Unspecified type

301.89 (F60.89) Other Specified Personality Disorder (684)

301.9 (F60.9) Unspecified Personality Disorder (684)

Paraphilic Disorders (685)

The following specifier applies to Paraphilic Disorders where indicated:
[a]*Specify* if: In a controlled environment, In full remission

302.82 (F65.3) Voyeuristic Disorder[a] (686)

302.4 (F65.2) Exhibitionistic Disorder[a] (689)
Specify whether: Sexually aroused by exposing genitals to prepubertal children, Sexually aroused by exposing genitals to physically mature individuals, Sexually aroused by exposing genitals to prepubertal children and to physically mature individuals

302.89 (F65.81) Frotteuristic Disorder[a] (691)

302.83 (F65.51) Sexual Masochism Disorder[a] (694)
Specify if: With asphyxiophilia

302.84 (F65.52) Sexual Sadism Disorder[a] (695)

302.2 (F65.4) Pedophilic Disorder (697)
Specify whether: Exclusive type, Nonexclusive type
Specify if: Sexually attracted to males, Sexually attracted to females, Sexually attracted to both
Specify if: Limited to incest

302.81 (F65.0) Fetishistic Disorder[a] (700)
Specify: Body part(s), Nonliving object(s), Other

302.3 (F65.1) Transvestic Disorder[a] (702)
Specify if: With fetishism, With autogynephilia

302.89 (F65.89) Other Specified Paraphilic Disorder (705)

302.9 (F65.9) Unspecified Paraphilic Disorder (705)

Other Mental Disorders (707)

294.8 (F06.8) Other Specified Mental Disorder Due to Another Medical Condition (707)

294.9 (F09) Unspecified Mental Disorder Due to Another Medical Condition (708)

300.9 (F99) Other Specified Mental Disorder (708)

300.9 (F99) Unspecified Mental Disorder (708)

Medication-Induced Movement Disorders and Other Adverse Effects of Medication (709)

332.1 (G21.11) Neuroleptic-Induced Parkinsonism (709)
332.1 (G21.19) Other Medication-Induced Parkinsonism (709)
333.92 (G21.0) Neuroleptic Malignant Syndrome (709)
333.72 (G24.02) Medication-Induced Acute Dystonia (711)
333.99 (G25.71) Medication-Induced Acute Akathisia (711)
333.85 (G24.01) Tardive Dyskinesia (712)
333.72 (G24.09) Tardive Dystonia (712)
333.99 (G25.71) Tardive Akathisia (712)
333.1 (G25.1) Medication-Induced Postural Tremor (712)
333.99 (G25.79) Other Medication-Induced Movement Disorder (712)

___.__ (___.__) Antidepressant Discontinuation Syndrome (712)
995.29 (T43.205A) Initial encounter
995.29 (T43.205D) Subsequent encounter
995.29 (T43.205S) Sequelae

___.__ (___.__) Other Adverse Effect of Medication (714)
995.20 (T50.905A) Initial encounter
995.20 (T50.905D) Subsequent encounter
995.20 (T50.905S) Sequelae

Other Conditions That May Be a Focus of Clinical Attention (715)

Relational Problems (715)

Problems Related to Family Upbringing (715)
V61.20 (Z62.820) Parent-Child Relational Problem (715)
V61.8 (Z62.891) Sibling Relational Problem (716)
V61.8 (Z62.29) Upbringing Away From Parents (716)
V61.29 (Z62.898) Child Affected by Parental Relationship Distress (716)

Other Problems Related to Primary Support Group (716)
V61.10 (Z63.0) Relationship Distress With Spouse or Intimate Partner (716)
V61.03 (Z63.5) Disruption of Family by Separation or Divorce (716)
V61.8 (Z63.8) High Expressed Emotion Level Within Family (716)
V62.82 (Z63.4) Uncomplicated Bereavement (716)

Abuse and Neglect (717)

Child Maltreatment and Neglect Problems (717)

Child Physical Abuse (717)

Child Physical Abuse, Confirmed (717)

995.54 (T74.12XA) Initial encounter

995.54 (T74.12XD) Subsequent encounter

Child Physical Abuse, Suspected (717)

995.54 (T76.12XA) Initial encounter

995.54 (T76.12XD) Subsequent encounter

Other Circumstances Related to Child Physical Abuse (718)

V61.21 (Z69.010) Encounter for mental health services for victim of child abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child abuse

V15.41 (Z62.810) Personal history (past history) of physical abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child abuse

Child Sexual Abuse (718)

Child Sexual Abuse, Confirmed (718)

995.53 (T74.22XA) Initial encounter

995.53 (T74.22XD) Subsequent encounter

Child Sexual Abuse, Suspected (718)

995.53 (T76.22XA) Initial encounter

995.53 (T76.22XD) Subsequent encounter

Other Circumstances Related to Child Sexual Abuse (718)

V61.21 (Z69.010) Encounter for mental health services for victim of child sexual abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child sexual abuse

V15.41 (Z62.810) Personal history (past history) of sexual abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child sexual abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child sexual abuse

Child Neglect (718)

Child Neglect, Confirmed (718)

995.52 (T74.02XA) Initial encounter

995.52 (T74.02XD) Subsequent encounter

Child Neglect, Suspected (719)

995.52 (T76.02XA) Initial encounter

995.52 (T76.02XD) Subsequent encounter

Other Circumstances Related to Child Neglect (719)

V61.21 (Z69.010) Encounter for mental health services for victim of child neglect by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child neglect

V15.42 (Z62.812) Personal history (past history) of neglect in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child neglect

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child neglect

Child Psychological Abuse (719)

Child Psychological Abuse, Confirmed (719)

995.51 (T74.32XA) Initial encounter

995.51 (T74.32XD) Subsequent encounter

Child Psychological Abuse, Suspected (719)

995.51 (T76.32XA) Initial encounter

995.51 (T76.32XD) Subsequent encounter

Other Circumstances Related to Child Psychological Abuse (719)

V61.21 (Z69.010) Encounter for mental health services for victim of child psychological abuse by parent

V61.21 (Z69.020) Encounter for mental health services for victim of nonparental child psychological abuse

V15.42 (Z62.811) Personal history (past history) of psychological abuse in childhood

V61.22 (Z69.011) Encounter for mental health services for perpetrator of parental child psychological abuse

V62.83 (Z69.021) Encounter for mental health services for perpetrator of nonparental child psychological abuse

Adult Maltreatment and Neglect Problems (720)

Spouse or Partner Violence, Physical (720)

Spouse or Partner Violence, Physical, Confirmed (720)

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Spouse or Partner Violence, Physical, Suspected (720)

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Physical (720)

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner violence, physical

V15.41 (Z91.410) Personal history (past history) of spouse or partner violence, physical

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner violence, physical

Spouse or Partner Violence, Sexual (720)

Spouse or Partner Violence, Sexual, Confirmed (720)

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Spouse or Partner Violence, Sexual, Suspected (720)

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Violence, Sexual (720)

V61.11 (Z69.81) Encounter for mental health services for victim of spouse or partner violence, sexual

V15.41 (Z91.410) Personal history (past history) of spouse or partner violence, sexual

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner violence, sexual

Spouse or Partner, Neglect (721)

Spouse or Partner Neglect, Confirmed (721)

995.85 (T74.01XA) Initial encounter

995.85 (T74.01XD) Subsequent encounter

Spouse or Partner Neglect, Suspected (721)

995.85 (T76.01XA) Initial encounter

995.85 (T76.01XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Neglect (721)

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner neglect

V15.42 (Z91.412) Personal history (past history) of spouse or partner neglect

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner neglect

Spouse or Partner Abuse, Psychological (721)

Spouse or Partner Abuse, Psychological, Confirmed (721)

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Spouse or Partner Abuse, Psychological, Suspected (721)

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Spouse or Partner Abuse, Psychological (721)

V61.11 (Z69.11) Encounter for mental health services for victim of spouse or partner psychological abuse

V15.42 (Z91.411) Personal history (past history) of spouse or partner psychological abuse

V61.12 (Z69.12) Encounter for mental health services for perpetrator of spouse or partner psychological abuse

Adult Abuse by Nonspouse or Nonpartner (722)

Adult Physical Abuse by Nonspouse or Nonpartner, Confirmed (722)

995.81 (T74.11XA) Initial encounter

995.81 (T74.11XD) Subsequent encounter

Adult Physical Abuse by Nonspouse or Nonpartner, Suspected (722)

995.81 (T76.11XA) Initial encounter

995.81 (T76.11XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Confirmed (722)

995.83 (T74.21XA) Initial encounter

995.83 (T74.21XD) Subsequent encounter

Adult Sexual Abuse by Nonspouse or Nonpartner, Suspected (722)

995.83 (T76.21XA) Initial encounter

995.83 (T76.21XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Confirmed (722)

995.82 (T74.31XA) Initial encounter

995.82 (T74.31XD) Subsequent encounter

Adult Psychological Abuse by Nonspouse or Nonpartner, Suspected (722)

995.82 (T76.31XA) Initial encounter

995.82 (T76.31XD) Subsequent encounter

Other Circumstances Related to Adult Abuse by Nonspouse or Nonpartner (722)

V65.49 (Z69.81) Encounter for mental health services for victim of nonspousal adult abuse

V62.83 (Z69.82) Encounter for mental health services for perpetrator of nonspousal adult abuse

Educational and Occupational Problems (723)

Educational Problems (723)

V62.3 (Z55.9) Academic or Educational Problem (723)

Occupational Problems (723)

V62.21 (Z56.82) Problem Related to Current Military Deployment Status (723)

V62.29 (Z56.9) Other Problem Related to Employment (723)

Housing and Economic Problems (723)

Housing Problems (723)

V60.0 (Z59.0) Homelessness (723)

V60.1 (Z59.1) Inadequate Housing (723)

V60.89 (Z59.2) Discord With Neighbor, Lodger, or Landlord (723)

V60.6 (Z59.3) Problem Related to Living in a Residential Institution (724)

Economic Problems (724)

V60.2 (Z59.4) Lack of Adequate Food or Safe Drinking Water (724)

V60.2 (Z59.5) Extreme Poverty (724)

V60.2 (Z59.6) Low Income (724)

V60.2 (Z59.7) Insufficient Social Insurance or Welfare Support (724)

V60.9 (Z59.9) Unspecified Housing or Economic Problem (724)

Other Problems Related to the Social Environment (724)

V62.89 (Z60.0) Phase of Life Problem (724)

V60.3 (Z60.2) Problem Related to Living Alone (724)

V62.4 (Z60.3) Acculturation Difficulty (724)

V62.4 (Z60.4) Social Exclusion or Rejection (724)

V62.4 (Z60.5) Target of (Perceived) Adverse Discrimination or Persecution (724)

V62.9 (Z60.9) Unspecified Problem Related to Social Environment (725)

Problems Related to Crime or Interaction With the Legal System (725)

V62.89 (Z65.4) Victim of Crime (725)

V62.5 (Z65.0) Conviction in Civil or Criminal Proceedings Without Imprisonment (725)

V62.5 (Z65.1) Imprisonment or Other Incarceration (725)

V62.5 (Z65.2) Problems Related to Release From Prison (725)

V62.5 (Z65.3) Problems Related to Other Legal Circumstances (725)

Other Health Service Encounters for Counseling and Medical Advice (725)

V65.49 (Z70.9) Sex Counseling (725)

V65.40 (Z71.9) Other Counseling or Consultation (725)

Problems Related to Other Psychosocial, Personal, and Environmental Circumstances (725)

V62.89 (Z65.8) Religious or Spiritual Problem (725)

V61.7 (Z64.0) Problems Related to Unwanted Pregnancy (725)

V61.5 (Z64.1) Problems Related to Multiparity (725)

V62.89 (Z64.4) Discord With Social Service Provider, Including Probation Officer, Case Manager, or Social Services Worker (725)

V62.89 (Z65.4) Victim of Terrorism or Torture (725)

V62.22 (Z65.5) Exposure to Disaster, War, or Other Hostilities (725)

V62.89 (Z65.8) Other Problem Related to Psychosocial Circumstances (725)

V62.9 (Z65.9) Unspecified Problem Related to Unspecified Psychosocial Circumstances (725)

Other Circumstances of Personal History (726)

V15.49 (Z91.49) Other Personal History of Psychological Trauma (726)

V15.59 (Z91.5) Personal History of Self-Harm (726)

V62.22 (Z91.82) Personal History of Military Deployment (726)

V15.89 (Z91.89) Other Personal Risk Factors (726)

V69.9 (Z72.9) Problem Related to Lifestyle (726)

V71.01 (Z72.811) Adult Antisocial Behavior (726)

V71.02 (Z72.810) Child or Adolescent Antisocial Behavior (726)

Problems Related to Access to Medical and Other Health Care (726)

V63.9 (Z75.3) Unavailability or Inaccessibility of Health Care Facilities (726)

V63.8 (Z75.4) Unavailability or Inaccessibility of Other Helping Agencies (726)

Nonadherence to Medical Treatment (726)

V15.81 (Z91.19) Nonadherence to Medical Treatment (726)

278.00 (E66.9) Overweight or Obesity (726)

V65.2 (Z76.5) Malingering (726)

V40.31 (Z91.83) Wandering Associated With a Mental Disorder (727)

V62.89 (R41.83) Borderline Intellectual Functioning (727)

Preface

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2014) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorders will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the "dementias" or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

specific molecular genetic findings for rare variants of Alzheimer's disease and Huntington's disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative "hybrid" model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at www.psychiatry.org/dsm5.

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assem-

bly review process. Special thanks go to Helena C. Kraemer, Ph.D., for her expert statistical consultation; Michael B. First, M.D., for his valuable input on the coding and review of criteria; and Paul S. Appelbaum, M.D., for feedback on forensic issues. Maria N. Ward, M.Ed., RHIT, CCS-P, also helped in verifying all ICD coding. The Summit Group, which included these consultants, the chairs of all review groups, the task force chairs, and the APA executive officers, chaired by Dilip V. Jeste, M.D., provided leadership and vision in helping to achieve compromise and consensus. This level of commitment has contributed to the balance and objectivity that we feel are hallmarks of DSM-5.

We especially wish to recognize the outstanding APA Division of Research staff—identified in the Task Force and Work Group listing at the front of this manual—who worked tirelessly to interact with the task force, work groups, advisors, and reviewers to resolve issues, serve as liaisons between the groups, direct and manage the academic and routine clinical practice field trials, and record decisions in this important process. In particular, we appreciate the support and guidance provided by James H. Scully Jr., M.D., Medical Director and CEO of the APA, through the years and travails of the development process. Finally, we thank the editorial and production staff of American Psychiatric Publishing—specifically, Rebecca Rinehart, Publisher; John McDuffie, Editorial Director; Ann Eng, Senior Editor; Greg Kuny, Managing Editor; and Tammy Cordova, Graphics Design Manager—for their guidance in bringing this all together and creating the final product. It is the culmination of efforts of many talented individuals who dedicated their time, expertise, and passion that made DSM-5 possible.

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December 19, 2012

SECTION I
DSM-5 Basics

Introduction 5
Use of the Manual 19
Cautionary Statement for Forensic Use of DSM-5 25

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This section is a basic orientation to the purpose, structure, content, and use of DSM-5. It is not intended to provide an exhaustive account of the evolution of DSM-5, but rather to give readers a succinct overview of its key elements. The introductory section describes the public, professional, and expert review process that was used to extensively evaluate the diagnostic criteria presented in Section II. A summary of the DSM-5 structure, harmonization with ICD-11, and the transition to a non-axial system with a new approach to assessing disability is also presented. “Use of the Manual” includes “Definition of a Mental Disorder,” forensic considerations, and a brief overview of the diagnostic process and use of coding and recording procedures.

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Introduction

The creation of the fifth edition of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) was a massive undertaking that involved hundreds of people working toward a common goal over a 12-year process. Much thought and deliberation were involved in evaluating the diagnostic criteria, considering the organization of every aspect of the manual, and creating new features believed to be most useful to clinicians. All of these efforts were directed toward the goal of enhancing the clinical usefulness of DSM-5 as a guide in the diagnosis of mental disorders.

Reliable diagnoses are essential for guiding treatment recommendations, identifying prevalence rates for mental health service planning, identifying patient groups for clinical and basic research, and documenting important public health information such as morbidity and mortality rates. As the understanding of mental disorders and their treatments has evolved, medical, scientific, and clinical professionals have focused on the characteristics of specific disorders and their implications for treatment and research.

While DSM has been the cornerstone of substantial progress in reliability, it has been well recognized by both the American Psychiatric Association (APA) and the broad scientific community working on mental disorders that past science was not mature enough to yield fully validated diagnoses—that is, to provide consistent, strong, and objective scientific validators of individual DSM disorders. The science of mental disorders continues to evolve. However, the last two decades since DSM-IV was released have seen real and durable progress in such areas as cognitive neuroscience, brain imaging, epidemiology, and genetics. The DSM-5 Task Force overseeing the new edition recognized that research advances will require careful, iterative changes if DSM is to maintain its place as the touchstone classification of mental disorders. Finding the right balance is critical. Speculative results do not belong in an official nosology, but at the same time, DSM must evolve in the context of other clinical research initiatives in the field. One important aspect of this transition derives from the broad recognition that a too-rigid categorical system does not capture clinical experience or important scientific observations. The results of numerous studies of comorbidity and disease transmission in families, including twin studies and molecular genetic studies, make strong arguments for what many astute clinicians have long observed: the boundaries between many disorder "categories" are more fluid over the life course than DSM-IV recognized, and many symptoms assigned to a single disorder may occur, at varying levels of severity, in many other disorders. These findings mean that DSM, like other medical disease classifications, should accommodate ways to introduce dimensional approaches to mental disorders, including dimensions that cut across current categories. Such an approach should permit a more accurate description of patient presentations and increase the validity of a diagnosis (i.e., the degree to which diagnostic criteria reflect the comprehensive manifestation of an underlying psychopathological disorder). DSM-5 is designed to better fill the need of clinicians, patients, families, and researchers for a clear and concise description of each mental disorder organized by explicit diagnostic criteria, supplemented, when appropriate, by dimensional measures that cross diagnostic boundaries, and a brief digest of information about the diagnosis, risk factors, associated features, research advances, and various expressions of the disorder.

Clinical training and experience are needed to use DSM for determining a diagnosis. The diagnostic criteria identify symptoms, behaviors, cognitive functions, personality traits, physical signs, syndrome combinations, and durations that require clinical expertise to differentiate from normal life variation and transient responses to stress. To facilitate a thorough

examination of the range of symptoms present, DSM can serve clinicians as a guide to identify the most prominent symptoms that should be assessed when diagnosing a disorder. Although some mental disorders may have well-defined boundaries around symptom clusters, scientific evidence now places many, if not most, disorders on a spectrum with closely related disorders that have shared symptoms, shared genetic and environmental risk factors, and possibly shared neural substrates (perhaps most strongly established for a subset of anxiety disorders by neuroimaging and animal models). In short, we have come to recognize that the boundaries between disorders are more porous than originally perceived.

Many health profession and educational groups have been involved in the development and testing of DSM-5, including physicians, psychologists, social workers, nurses, counselors, epidemiologists, statisticians, neuroscientists, and neuropsychologists. Finally, patients, families, lawyers, consumer organizations, and advocacy groups have all participated in revising DSM-5 by providing feedback on the mental disorders described in this volume. Their monitoring of the descriptions and explanatory text is essential to improve understanding, reduce stigma, and advance the treatment and eventual cures for these conditions.

A Brief History

The APA first published a predecessor of DSM in 1844, as a statistical classification of institutionalized mental patients. It was designed to improve communication about the types of patients cared for in these hospitals. This forerunner to DSM also was used as a component of the full U.S. census. After World War II, DSM evolved through four major editions into a diagnostic classification system for psychiatrists, other physicians, and other mental health professionals that described the essential features of the full range of mental disorders. The current edition, DSM-5, builds on the goal of its predecessors (most recently, DSM-IV-TR, or Text Revision, published in 2000) of providing guidelines for diagnoses that can inform treatment and management decisions.

DSM-5 Revision Process

In 1999, the APA launched an evaluation of the strengths and weaknesses of DSM based on emerging research that did not support the boundaries established for some mental disorders. This effort was coordinated with the World Health Organization (WHO) Division of Mental Health, the World Psychiatric Association, and the National Institute of Mental Health (NIMH) in the form of several conferences, the proceedings of which were published in 2002 in a monograph entitled *A Research Agenda for DSM-V*. Thereafter, from 2003 to 2008, a cooperative agreement with the APA and the WHO was supported by the NIMH, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcoholism and Alcohol Abuse (NIAAA) to convene 13 international DSM-5 research planning conferences, involving 400 participants from 39 countries, to review the world literature in specific diagnostic areas to prepare for revisions in developing both DSM-5 and the *International Classification of Diseases,* 11th Revision (ICD-11). Reports from these conferences formed the basis for future DSM-5 Task Force reviews and set the stage for the new edition of DSM.

In 2006, the APA named David J. Kupfer, M.D., as Chair and Darrel A. Regier, M.D., M.P.H., as Vice-Chair of the DSM-5 Task Force. They were charged with recommending chairs for the 13 diagnostic work groups and additional task force members with a multidisciplinary range of expertise who would oversee the development of DSM-5. An additional vetting process was initiated by the APA Board of Trustees to disclose sources of income and thus avoid conflicts of interest by task force and work group members. The full disclosure of all income and research grants from commercial sources, including the pharmaceutical industry, in the previous 3 years, the imposition of an income cap from all commercial sources, and the publication of disclosures on a Web site set a new standard for the

field. Thereafter, the task force of 28 members was approved in 2007, and appointments of more than 130 work group members were approved in 2008. More than 400 additional work group advisors with no voting authority were also approved to participate in the process. A clear concept of the next evolutionary stage for the classification of mental disorders was central to the efforts of the task force and the work groups. This vision emerged as the task force and work groups recounted the history of DSM-IV's classification, its current strengths and limitations, and strategic directions for its revision. An intensive 6-year process involved conducting literature reviews and secondary analyses, publishing research reports in scientific journals, developing draft diagnostic criteria, posting preliminary drafts on the DSM-5 Web site for public comment, presenting preliminary findings at professional meetings, performing field trials, and revising criteria and text.

Proposals for Revisions

Proposals for the revision of DSM-5 diagnostic criteria were developed by members of the work groups on the basis of rationale, scope of change, expected impact on clinical management and public health, strength of the supporting research evidence, overall clarity, and clinical utility. Proposals encompassed changes to diagnostic criteria; the addition of new disorders, subtypes, and specifiers; and the deletion of existing disorders.

In the proposals for revisions, strengths and weaknesses in the current criteria and nosology were first identified. Novel scientific findings over the previous two decades were considered, leading to the creation of a research plan to assess potential changes through literature reviews and secondary data analyses. Four principles guided the draft revisions: 1) DSM-5 is primarily intended to be a manual to be used by clinicians, and revisions must be feasible for routine clinical practice; 2) recommendations for revisions should be guided by research evidence; 3) where possible, continuity should be maintained with previous editions of DSM; and 4) no a priori constraints should be placed on the degree of change between DSM-IV and DSM-5.

Building on the initial literature reviews, work groups identified key issues within their diagnostic areas. Work groups also examined broader methodological concerns, such as the presence of contradictory findings within the literature; development of a refined definition of mental disorder; cross-cutting issues relevant to all disorders; and the revision of disorders categorized in DSM-IV as "not otherwise specified." Inclusion of a proposal for revision in Section II was informed by consideration of its advantages and disadvantages for public health and clinical utility, the strength of the evidence, and the magnitude of the change. New diagnoses and disorder subtypes and specifiers were subject to additional stipulations, such as demonstration of reliability (i.e., the degree to which two clinicians could independently arrive at the same diagnosis for a given patient). Disorders with low clinical utility and weak validity were considered for deletion. Placement of conditions in "Conditions for Further Study" in Section III was contingent on the amount of empirical evidence generated on the diagnosis, diagnostic reliability or validity, presence of clear clinical need, and potential benefit in advancing research.

DSM-5 Field Trials

The use of field trials to empirically demonstrate reliability was a noteworthy improvement introduced in DSM-III. The design and implementation strategy of the DSM-5 Field Trials represent several changes over approaches used for DSM-III and DSM-IV, particularly in obtaining data on the precision of kappa reliability estimates (a statistical measure that assesses level of agreement between raters that corrects for chance agreement due to prevalence rates) in the context of clinical settings with high levels of diagnostic comorbidity. For DSM-5, field trials were extended by using two distinctive designs: one in large, diverse medical-academic settings, and the other in routine clinical practices. The former capitalized on the need for large sample sizes to test hypotheses on reliability and clinical utility of a range of diagnoses in a

variety of patient populations; the latter supplied valuable information about how proposed revisions performed in everyday clinical settings among a diverse sample of DSM users. It is anticipated that future clinical and basic research studies will focus on the validity of the revised categorical diagnostic criteria and the underlying dimensional features of these disorders (including those now being explored by the NIMH Research Domain Criteria initiative).

The medical-academic field trials were conducted at 11 North American medical-academic sites and assessed the reliability, feasibility, and clinical utility of select revisions, with priority given to those that represented the greatest degree of change from DSM-IV or those potentially having the greatest public health impact. The full clinical patient populations coming to each site were screened for DSM-IV diagnoses or qualifying symptoms likely to predict several specific DSM-5 disorders of interest. Stratified samples of four to seven specific disorders, plus a stratum containing a representative sample of all other diagnoses, were identified for each site. Patients consented to the study and were randomly assigned for a clinical interview by a clinician blind to the diagnosis, followed by a second interview with a clinician blind to previous diagnoses. Patients first filled out a computer-assisted inventory of cross-cutting symptoms in more than a dozen psychological domains. These inventories were scored by a central server, and results were provided to clinicians before they conducted a typical clinical interview (with no structured protocol). Clinicians were required to score the presence of qualifying criteria on a computer-assisted DSM-5 diagnostic checklist, determine diagnoses, score the severity of the diagnosis, and submit all data to the central Web-based server. This study design allowed the calculation of the degree to which two independent clinicians could agree on a diagnosis (using the intraclass kappa statistic) and the agreement of a single patient or two different clinicians on two separate ratings of cross-cutting symptoms, personality traits, disability, and diagnostic severity measures (using intraclass correlation coefficients) along with information on the precision of these estimates of reliability. It was also possible to assess the prevalence rates of both DSM-IV and DSM-5 conditions in the respective clinical populations.

The routine clinical practice field trials involved recruitment of individual psychiatrists and other mental health clinicians. A volunteer sample was recruited that included generalist and specialty psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice psychiatric mental health nurses. The field trials provided exposure of the proposed DSM-5 diagnoses and dimensional measures to a wide range of clinicians to assess their feasibility and clinical utility.

Public and Professional Review

In 2010, the APA launched a unique Web site to facilitate public and professional input into DSM-5. All draft diagnostic criteria and proposed changes in organization were posted on www.dsm5.org for a 2-month comment period. Feedback totaled more than 8,000 submissions, which were systematically reviewed by each of the 13 work groups, whose members, where appropriate, integrated questions and comments into discussions of draft revisions and plans for field trial testing. After revisions to the initial draft criteria and proposed chapter organization, a second posting occurred in 2011. Work groups considered feedback from both Web postings and the results of the DSM-5 Field Trials when drafting proposed final criteria, which were posted on the Web site for a third and final time in 2012. These three iterations of external review produced more than 13,000 individually signed comments on the Web site that were received and reviewed by the work groups, plus thousands of organized petition signers for and against some proposed revisions, all of which allowed the task force to actively address concerns of DSM users, as well as patients and advocacy groups, and ensure that clinical utility remained a high priority.

Expert Review

The members of the 13 work groups, representing expertise in their respective areas, collaborated with advisors and reviewers under the overall direction of the DSM-5 Task

Force to draft the diagnostic criteria and accompanying text. This effort was supported by a team of APA Division of Research staff and developed through a network of text coordinators from each work group. The preparation of the text was coordinated by the text editor, working in close collaboration with the work groups and under the direction of the task force chairs. The Scientific Review Committee (SRC) was established to provide a scientific peer review process that was external to that of the work groups. The SRC chair, vice-chair, and six committee members were charged with reviewing the degree to which the proposed changes from DSM-IV could be supported with scientific evidence. Each proposal for diagnostic revision required a memorandum of evidence for change prepared by the work group and accompanied by a summary of supportive data organized around validators for the proposed diagnostic criteria (i.e., antecedent validators such as familial aggregation, concurrent validators such as biological markers, and prospective validators such as response to treatment or course of illness). The submissions were reviewed by the SRC and scored according to the strength of the supportive scientific data. Other justifications for change, such as those arising from clinical experience or need or from a conceptual reframing of diagnostic categories, were generally seen as outside the purview of the SRC. The reviewers' scores, which varied substantially across the different proposals, and an accompanying brief commentary were then returned to the APA Board of Trustees and the work groups for consideration and response.

The Clinical and Public Health Committee (CPHC), composed of a chair, vice-chair, and six members, was appointed to consider additional clinical utility, public health, and logical clarification issues for criteria that had not yet accumulated the type or level of evidence deemed sufficient for change by the SRC. This review process was particularly important for DSM-IV disorders with known deficiencies for which proposed remedies had neither been previously considered in the DSM revision process nor been subjected to replicated research studies. These selected disorders were evaluated by four to five external reviewers, and the blinded results were reviewed by CPHC members, who in turn made recommendations to the APA Board of Trustees and the work groups.

Forensic reviews by the members of the APA Council on Psychiatry and Law were conducted for disorders frequently appearing in forensic environments and ones with high potential for influencing civil and criminal judgments in courtroom settings. Work groups also added forensic experts as advisors in pertinent areas to complement expertise provided by the Council on Psychiatry and Law.

The work groups themselves were charged with the responsibility to review the entire research literature surrounding a diagnostic area, including old, revised, and new diagnostic criteria, in an intensive 6-year review process to assess the pros and cons of making either small iterative changes or major conceptual changes to address the inevitable reification that occurs with diagnostic conceptual approaches that persist over several decades. Such changes included the merger of previously separate diagnostic areas into more dimensional spectra, such as that which occurred with autism spectrum disorder, substance use disorders, sexual dysfunctions, and somatic symptom and related disorders. Other changes included correcting flaws that had become apparent over time in the choice of operational criteria for some disorders. These types of changes posed particular challenges to the SRC and CPHC review processes, which were not constructed to evaluate the validity of DSM-IV diagnostic criteria. However, the DSM-5 Task Force, which had reviewed proposed changes and had responsibility for reviewing the text describing each disorder contemporaneously with the work groups during this period, was in a unique position to render an informed judgment on the scientific merits of such revisions. Furthermore, many of these major changes were subject to field trial testing, although comprehensive testing of all proposed changes could not be accommodated by such testing because of time limitations and availability of resources.

A final recommendation from the task force was then provided to the APA Board of Trustees and the APA Assembly's Committee on DSM-5 to consider some of the clinical utility and feasibility features of the proposed revisions. The assembly is a deliberative

body of the APA representing the district branches and wider membership that is composed of psychiatrists from throughout the United States who provide geographic, practice size, and interest-based diversity. The Committee on DSM-5 is a committee made up of a diverse group of assembly leaders.

Following all of the preceding review steps, an executive "summit committee" session was held to consolidate input from review and assembly committee chairs, task force chairs, a forensic advisor, and a statistical advisor, for a preliminary review of each disorder by the assembly and APA Board of Trustees executive committees. This preceded a preliminary review by the full APA Board of Trustees. The assembly voted, in November 2012, to recommend that the board approve the publication of DSM-5, and the APA Board of Trustees approved its publication in December 2012. The many experts, reviewers, and advisors who contributed to this process are listed in the Appendix.

Organizational Structure

The individual disorder definitions that constitute the operationalized sets of diagnostic criteria provide the core of DSM-5 for clinical and research purposes. These criteria have been subjected to scientific review, albeit to varying degrees, and many disorders have undergone field testing for interrater reliability. In contrast, the classification of disorders (the way in which disorders are grouped, which provides a high-level organization for the manual) has not generally been thought of as scientifically significant, despite the fact that judgments had to be made when disorders were initially divided into chapters for DSM-III.

DSM is a medical classification of disorders and as such serves as a historically determined cognitive schema imposed on clinical and scientific information to increase its comprehensibility and utility. Not surprisingly, as the foundational science that ultimately led to DSM-III has approached a half-century in age, challenges have begun to emerge for clinicians and scientists alike that are inherent in the DSM structure rather than in the description of any single disorder. These challenges include high rates of comorbidity within and across DSM chapters, an excessive use of and need to rely on "not otherwise specified" (NOS) criteria, and a growing inability to integrate DSM disorders with the results of genetic studies and other scientific findings.

As the APA and the WHO began to plan their respective revisions of the DSM and the *International Classification of Disorders* (ICD), both considered the possibility of improving clinical utility (e.g., by helping to explain apparent comorbidity) and facilitating scientific investigation by rethinking the organizational structures of both publications in a linear system designated by alphanumeric codes that sequence chapters according to some rational and relational structure. It was critical to both the DSM-5 Task Force and the WHO International Advisory Group on the revision of the ICD-10 Section on Mental and Behavioral Disorders that the revisions to the organization enhance clinical utility and remain within the bounds of well-replicated scientific information. Although the need for reform seemed apparent, it was important to respect the state of the science as well as the challenge that overly rapid change would pose for the clinical and research communities. In that spirit, revision of the organization was approached as a conservative, evolutionary diagnostic reform that would be guided by emerging scientific evidence on the relationships between disorder groups. By reordering and regrouping the existing disorders, the revised structure is meant to stimulate new clinical perspectives and to encourage researchers to identify the psychological and physiological cross-cutting factors that are not bound by strict categorical designations.

The use of DSM criteria has the clear virtue of creating a common language for communication between clinicians about the diagnosis of disorders. The official criteria and disorders that were determined to have accepted clinical applicability are located in Section II of the manual. However, it should be noted that these diagnostic criteria and their

relationships within the classification are based on current research and may need to be modified as new evidence is gathered by future research both within and across the domains of proposed disorders. "Conditions for Further Study," described in Section III, are those for which we determined that the scientific evidence is not yet available to support widespread clinical use. These diagnostic criteria are included to highlight the evolution and direction of scientific advances in these areas to stimulate further research.

With any ongoing review process, especially one of this complexity, different viewpoints emerge, and an effort was made to consider various viewpoints and, when warranted, accommodate them. For example, personality disorders are included in both Sections II and III. Section II represents an update of the text associated with the same criteria found in DSM-IV-TR, whereas Section III includes the proposed research model for personality disorder diagnosis and conceptualization developed by the DSM-5 Personality and Personality Disorders Work Group. As this field evolves, it is hoped that both versions will serve clinical practice and research initiatives.

Harmonization With ICD-11

The groups tasked with revising the DSM and ICD systems shared the overarching goal of harmonizing the two classifications as much as possible, for the following reasons:

- The existence of two major classifications of mental disorders hinders the collection and use of national health statistics, the design of clinical trials aimed at developing new treatments, and the consideration of global applicability of the results by international regulatory agencies.
- More broadly, the existence of two classifications complicates attempts to replicate scientific results across national boundaries.
- Even when the intention was to identify identical patient populations, DSM-IV and ICD-10 diagnoses did not always agree.

Early in the course of the revisions, it became apparent that a shared organizational structure would help harmonize the classifications. In fact, the use of a shared framework helped to integrate the work of DSM and ICD work groups and to focus on scientific issues. The DSM-5 organization and the proposed linear structure of the ICD-11 have been endorsed by the leadership of the NIMH Research Domain Criteria (RDoC) project as consistent with the initial overall structure of that project.

Of course, principled disagreements on the classification of psychopathology and on specific criteria for certain disorders were expected given the current state of scientific knowledge. However, most of the salient differences between the DSM and the ICD classifications do not reflect real scientific differences, but rather represent historical by-products of independent committee processes.

To the surprise of participants in both revision processes, large sections of the content fell relatively easily into place, reflecting real strengths in some areas of the scientific literature, such as epidemiology, analyses of comorbidity, twin studies, and certain other genetically informed designs. When disparities emerged, they almost always reflected the need to make a judgment about where to place a disorder in the face of incomplete—or, more often, conflicting—data. Thus, for example, on the basis of patterns of symptoms, comorbidity, and shared risk factors, attention-deficit/hyperactivity disorder (ADHD) was placed with neurodevelopmental disorders, but the same data also supported strong arguments to place ADHD within disruptive, impulse-control, and conduct disorders. These issues were settled with the preponderance of evidence (most notably validators approved by the DSM-5 Task Force). The work groups recognize, however, that future discoveries might change the placement as well as the contours of individual disorders and, furthermore, that the simple and linear organization that best supports clinical practice

may not fully capture the complexity and heterogeneity of mental disorders. The revised organization is coordinated with the mental and behavioral disorders chapter (Chapter V) of ICD-11, which will utilize an expanded numeric–alphanumeric coding system. However, the official coding system in use in the United States at the time of publication of this manual is that of the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM)—the U.S. adaptation of ICD-9. *International Classification of Diseases, Tenth Revision, Clinical Modification* (ICD-10-CM), adapted from ICD-10, is scheduled for implementation in the United States in October 2014. Given the impending release of ICD-11, it was decided that this iteration, and not ICD-10, would be the most relevant on which to focus harmonization. However, given that adoption of the ICD-9-CM coding system will remain at the time of the DSM-5 release, it will be necessary to use the ICD-9-CM codes. Furthermore, given that DSM-5's organizational structure reflects the anticipated structure of ICD-11, the eventual ICD-11 codes will follow the sequential order of diagnoses in the DSM-5 chapter structure more closely. At present, both the ICD-9-CM and the ICD-10-CM codes have been indicated for each disorder. These codes will not be in sequential order throughout the manual because they were assigned to complement earlier organizational structures.

Dimensional Approach to Diagnosis

Structural problems rooted in the basic design of the previous DSM classification, constructed of a large number of narrow diagnostic categories, have emerged in both clinical practice and research. Relevant evidence comes from diverse sources, including studies of comorbidity and the substantial need for not otherwise specified diagnoses, which represent the majority of diagnoses in areas such as eating disorders, personality disorders, and autism spectrum disorder. Studies of both genetic and environmental risk factors, whether based on twin designs, familial transmission, or molecular analyses, also raise concerns about the categorical structure of the DSM system. Because the previous DSM approach considered each diagnosis as categorically separate from health and from other diagnoses, it did not capture the widespread sharing of symptoms and risk factors across many disorders that is apparent in studies of comorbidity. Earlier editions of DSM focused on excluding false-positive results from diagnoses; thus, its categories were overly narrow, as is apparent from the widespread need to use NOS diagnoses. Indeed, the once plausible goal of identifying homogeneous populations for treatment and research resulted in narrow diagnostic categories that did not capture clinical reality, symptom heterogeneity within disorders, and significant sharing of symptoms across multiple disorders. The historical aspiration of achieving diagnostic homogeneity by progressive subtyping within disorder categories no longer is sensible; like most common human ills, mental disorders are heterogeneous at many levels, ranging from genetic risk factors to symptoms.

Related to recommendations about alterations in the chapter structure of DSM-5, members of the diagnostic spectra study group examined whether scientific validators could inform possible new groupings of related disorders within the existing categorical framework. Eleven such indicators were recommended for this purpose: shared neural substrates, family traits, genetic risk factors, specific environmental risk factors, biomarkers, temperamental antecedents, abnormalities of emotional or cognitive processing, symptom similarity, course of illness, high comorbidity, and shared treatment response. These indicators served as empirical guidelines to inform decision making by the work groups and the task force about how to cluster disorders to maximize their validity and clinical utility.

A series of papers was developed and published in a prominent international journal (*Psychological Medicine,* Vol. 39, 2009) as part of both the DSM-5 and the ICD-11 developmental processes to document that such validators were most useful for suggesting large groupings of disorders rather than for "validating" individual disorder diagnostic criteria. The regrouping of mental disorders in DSM-5 is intended to enable future research to en-

hance understanding of disease origins and pathophysiological commonalities between disorders and provide a base for future replication wherein data can be reanalyzed over time to continually assess validity. Ongoing revisions of DSM-5 will make it a "living document," adaptable to future discoveries in neurobiology, genetics, and epidemiology.

On the basis of the published findings of this common DSM-5 and ICD-11 analysis, it was demonstrated that clustering of disorders according to what has been termed *internalizing* and *externalizing* factors represents an empirically supported framework. Within both the internalizing group (representing disorders with prominent anxiety, depressive, and somatic symptoms) and the externalizing group (representing disorders with prominent impulsive, disruptive conduct, and substance use symptoms), the sharing of genetic and environmental risk factors, as shown by twin studies, likely explains much of the systematic comorbidities seen in both clinical and community samples. The adjacent placement of "internalizing disorders," characterized by depressed mood, anxiety, and related physiological and cognitive symptoms, should aid in developing new diagnostic approaches, including dimensional approaches, while facilitating the identification of biological markers. Similarly, adjacencies of the "externalizing group," including disorders exhibiting antisocial behaviors, conduct disturbances, addictions, and impulse-control disorders, should encourage advances in identifying diagnoses, markers, and underlying mechanisms.

Despite the problem posed by categorical diagnoses, the DSM-5 Task Force recognized that it is premature scientifically to propose alternative definitions for most disorders. The organizational structure is meant to serve as a bridge to new diagnostic approaches without disrupting current clinical practice or research. With support from DSM-associated training materials, the National Institutes of Health other funding agencies, and scientific publications, the more dimensional DSM-5 approach and organizational structure can facilitate research across current diagnostic categories by encouraging broad investigations within the proposed chapters and across adjacent chapters. Such a reformulation of research goals should also keep DSM-5 central to the development of dimensional approaches to diagnosis that will likely supplement or supersede current categorical approaches in coming years.

Developmental and Lifespan Considerations

To improve clinical utility, DSM-5 is organized on developmental and lifespan considerations. It begins with diagnoses thought to reflect developmental processes that manifest early in life (e.g., neurodevelopmental and schizophrenia spectrum and other psychotic disorders), followed by diagnoses that more commonly manifest in adolescence and young adulthood (e.g., bipolar, depressive, and anxiety disorders), and ends with diagnoses relevant to adulthood and later life (e.g., neurocognitive disorders). A similar approach has been taken, where possible, within each chapter. This organizational structure facilitates the comprehensive use of lifespan information as a way to assist in diagnostic decision making.

The proposed organization of chapters of DSM-5, after the neurodevelopmental disorders, is based on groups of internalizing (emotional and somatic) disorders, externalizing disorders, neurocognitive disorders, and other disorders. It is hoped that this organization will encourage further study of underlying pathophysiological processes that give rise to diagnostic comorbidity and symptom heterogeneity. Furthermore, by arranging disorder clusters to mirror clinical reality, DSM-5 should facilitate identification of potential diagnoses by non–mental health specialists, such as primary care physicians.

The organizational structure of DSM-5, along with ICD harmonization, is designed to provide better and more flexible diagnostic concepts for the next epoch of research and to serve as a useful guide to clinicians in explaining to patients why they might have received multiple diagnoses or why they might have received additional or altered diagnoses over their lifespan.

Cultural Issues

Mental disorders are defined in relation to cultural, social, and familial norms and values. Culture provides interpretive frameworks that shape the experience and expression of the symptoms, signs, and behaviors that are criteria for diagnosis. Culture is transmitted, revised, and recreated within the family and other social systems and institutions. Diagnostic assessment must therefore consider whether an individual's experiences, symptoms, and behaviors differ from sociocultural norms and lead to difficulties in adaptation in the cultures of origin and in specific social or familial contexts. Key aspects of culture relevant to diagnostic classification and assessment have been considered in the development of DSM-5.

In Section III, the "Cultural Formulation" contains a detailed discussion of culture and diagnosis in DSM-5, including tools for in-depth cultural assessment. In the Appendix, the "Glossary of Cultural Concepts of Distress" provides a description of some common cultural syndromes, idioms of distress, and causal explanations relevant to clinical practice.

The boundaries between normality and pathology vary across cultures for specific types of behaviors. Thresholds of tolerance for specific symptoms or behaviors differ across cultures, social settings, and families. Hence, the level at which an experience becomes problematic or pathological will differ. The judgment that a given behavior is abnormal and requires clinical attention depends on cultural norms that are internalized by the individual and applied by others around them, including family members and clinicians. Awareness of the significance of culture may correct mistaken interpretations of psychopathology, but culture may also contribute to vulnerability and suffering (e.g., by amplifying fears that maintain panic disorder or health anxiety). Cultural meanings, habits, and traditions can also contribute to either stigma or support in the social and familial response to mental illness. Culture may provide coping strategies that enhance resilience in response to illness, or suggest help seeking and options for accessing health care of various types, including alternative and complementary health systems. Culture may influence acceptance or rejection of a diagnosis and adherence to treatments, affecting the course of illness and recovery. Culture also affects the conduct of the clinical encounter; as a result, cultural differences between the clinician and the patient have implications for the accuracy and acceptance of diagnosis as well as for treatment decisions, prognostic considerations, and clinical outcomes.

Historically, the construct of the culture-bound syndrome has been a key interest of cultural psychiatry. In DSM-5, this construct has been replaced by three concepts that offer greater clinical utility:

1. *Cultural syndrome* is a cluster or group of co-occurring, relatively invariant symptoms found in a specific cultural group, community, or context (e.g., *ataque de nervios*). The syndrome may or may not be recognized as an illness within the culture (e.g., it might be labeled in various ways), but such cultural patterns of distress and features of illness may nevertheless be recognizable by an outside observer.
2. *Cultural idiom of distress* is a linguistic term, phrase, or way of talking about suffering among individuals of a cultural group (e.g., similar ethnicity and religion) referring to shared concepts of pathology and ways of expressing, communicating, or naming essential features of distress (e.g., *kufungisisa*). An idiom of distress need not be associated with specific symptoms, syndromes, or perceived causes. It may be used to convey a wide range of discomfort, including everyday experiences, subclinical conditions, or suffering due to social circumstances rather than mental disorders. For example, most cultures have common bodily idioms of distress used to express a wide range of suffering and concerns.
3. *Cultural explanation or perceived cause* is a label, attribution, or feature of an explanatory model that provides a culturally conceived etiology or cause for symptoms, illness, or distress (e.g., *maladi moun*). Causal explanations may be salient features of folk classifications of disease used by laypersons or healers.

These three concepts (for which discussion and examples are provided in Section III and the Appendix) suggest cultural ways of understanding and describing illness experiences that can be elicited in the clinical encounter. They influence symptomatology, help seeking, clinical presentations, expectations of treatment, illness adaptation, and treatment response. The same cultural term often serves more than one of these functions.

Gender Differences

Sex and gender differences as they relate to the causes and expression of medical conditions are established for a number of diseases, including selected mental disorders. Revisions to DSM-5 included review of potential differences between men and women in the expression of mental illness. In terms of nomenclature, *sex differences* are variations attributable to an individual's reproductive organs and XX or XY chromosomal complement. *Gender differences* are variations that result from biological sex as well as an individual's self-representation that includes the psychological, behavioral, and social consequences of one's perceived gender. The term *gender differences* is used in DSM-5 because, more commonly, the differences between men and women are a result of both biological sex and individual self-representation. However, some of the differences are based on only biological sex.

Gender can influence illness in a variety of ways. First, it may exclusively determine whether an individual is at risk for a disorder (e.g., as in premenstrual dysphoric disorder). Second, gender may moderate the overall risk for development of a disorder as shown by marked gender differences in the prevalence and incidence rates for selected mental disorders. Third, gender may influence the likelihood that particular symptoms of a disorder are experienced by an individual. Attention-deficit/hyperactivity disorder is an example of a disorder with differences in presentation that are most commonly experienced by boys or girls. Gender likely has other effects on the experience of a disorder that are indirectly relevant to psychiatric diagnosis. It may be that certain symptoms are more readily endorsed by men or women, and that this contributes to differences in service provision (e.g., women may be more likely to recognize a depressive, bipolar, or anxiety disorder and endorse a more comprehensive list of symptoms than men).

Reproductive life cycle events, including estrogen variations, also contribute to gender differences in risk and expression of illness. Thus, a specifier for postpartum onset of mania or major depressive episode denotes a time frame wherein women may be at increased risk for the onset of an illness episode. In the case of sleep and energy, alterations are often normative postpartum and thus may have lower diagnostic reliability in postpartum women.

The manual is configured to include information on gender at multiple levels. If there are gender-specific symptoms, they have been added to the diagnostic criteria. A gender-related specifier, such as perinatal onset of a mood episode, provides additional information on gender and diagnosis. Finally, other issues that are pertinent to diagnosis and gender considerations can be found in the section "Gender-Related Diagnostic Issues."

Use of Other Specified and Unspecified Disorders

To enhance diagnostic specificity, DSM-5 replaces the previous NOS designation with two options for clinical use: *other specified disorder* and *unspecified disorder*. The other specified disorder category is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason. For example, for an individual with clinically significant depressive symptoms lasting 4 weeks but whose symptomatology falls short of the diagnostic threshold for a major depressive episode, the clinician would record "other specified depressive disorder, depressive episode with insufficient symptoms." If the clinician chooses not to specify the

reason that the criteria are not met for a specific disorder, then "unspecified depressive disorder" would be diagnosed. Note that the differentiation between other specified and unspecified disorders is based on the clinician's decision, providing maximum flexibility for diagnosis. Clinicians do not have to differentiate between other specified and unspecified disorders based on some feature of the presentation itself. When the clinician determines that there is evidence to specify the nature of the clinical presentation, the other specified diagnosis can be given. When the clinician is not able to further specify and describe the clinical presentation, the unspecified diagnosis can be given. This is left entirely up to clinical judgment.

For a more detailed discussion of how to use other specified and unspecified designations, see "Use of the Manual" in Section I.

The Multiaxial System

Despite widespread use and its adoption by certain insurance and governmental agencies, the multiaxial system in DSM-IV was not required to make a mental disorder diagnosis. A nonaxial assessment system was also included that simply listed the appropriate Axis I, II, and III disorders and conditions without axial designations. DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II, and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V). This revision is consistent with the DSM-IV text that states, "The multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes." The approach of separately noting diagnosis from psychosocial and contextual factors is also consistent with established WHO and ICD guidance to consider the individual's functional status separately from his or her diagnoses or symptom status. In DSM-5, Axis III has been combined with Axes I and II. Clinicians should continue to list medical conditions that are important to the understanding or management of an individual's mental disorder(s).

DSM-IV Axis IV covered psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders. Although this axis provided helpful information, even if it was not used as frequently as intended, the DSM-5 Task Force recommended that DSM-5 should not develop its own classification of psychosocial and environmental problems, but rather use a selected set of the ICD-9-CM V codes and the new Z codes contained in ICD-10-CM. The ICD-10 Z codes were examined to determine which are most relevant to mental disorders and also to identify gaps.

DSM-IV Axis V consisted of the Global Assessment of Functioning (GAF) scale, representing the clinician's judgment of the individual's overall level of "functioning on a hypothetical continuum of mental health–illness." It was recommended that the GAF be dropped from DSM-5 for several reasons, including its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in its descriptors) and questionable psychometrics in routine practice. In order to provide a global measure of disability, the WHO Disability Assessment Schedule (WHODAS) is included, for further study, in Section III of DSM-5 (see the chapter "Assessment Measures"). The WHODAS is based on the International Classification of Functioning, Disability and Health (ICF) for use across all of medicine and health care. The WHODAS (version 2.0), and a modification developed for children/adolescents and their parents by the Impairment and Disability Study Group were included in the DSM-5 field trial.

Online Enhancements

It was challenging to determine what to include in the print version of DSM-5 to be most clinically relevant and useful and at the same time maintain a manageable size. For this reason, the inclusion of clinical rating scales and measures in the print edition is limited to those considered most relevant. Additional assessment measures used in the field trials are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. The Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also available online at www.psychiatry.org/dsm5.

DSM-5 is available as an online subscription at PsychiatryOnline.org as well as an e-book. The online component contains modules and assessment tools to enhance the diagnostic criteria and text. Also available online is a complete set of supportive references as well as additional helpful information. The organizational structure of DSM-5, its use of dimensional measures, and compatibility with ICD codes will allow it to be readily adaptable to future scientific discoveries and refinements in its clinical utility. DSM-5 will be analyzed over time to continually assess its validity and enhance its value to clinicians.

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Use of the Manual

The introduction contains much of the history and developmental process of the DSM-5 revision. This section is designed to provide a practical guide to using DSM-5, particularly in clinical practice. The primary purpose of DSM-5 is to assist trained clinicians in the diagnosis of their patients' mental disorders as part of a case formulation assessment that leads to a fully informed treatment plan for each individual. The symptoms contained in the respective diagnostic criteria sets do not constitute comprehensive definitions of underlying disorders, which encompass cognitive, emotional, behavioral, and physiological processes that are far more complex than can be described in these brief summaries. Rather, they are intended to summarize characteristic syndromes of signs and symptoms that point to an underlying disorder with a characteristic developmental history, biological and environmental risk factors, neuropsychological and physiological correlates, and typical clinical course.

Approach to Clinical Case Formulation

The case formulation for any given patient must involve a careful clinical history and concise summary of the social, psychological, and biological factors that may have contributed to developing a given mental disorder. Hence, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a mental disorder diagnosis. Although a systematic check for the presence of these criteria as they apply to each patient will assure a more reliable assessment, the relative severity and valence of individual criteria and their contribution to a diagnosis require clinical judgment. The symptoms in our diagnostic criteria are part of the relatively limited repertoire of human emotional responses to internal and external stresses that are generally maintained in a homeostatic balance without a disruption in normal functioning. It requires clinical training to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges. The ultimate goal of a clinical case formulation is to use the available contextual and diagnostic information in developing a comprehensive treatment plan that is informed by the individual's cultural and social context. However, recommendations for the selection and use of the most appropriate evidence-based treatment options for each disorder are beyond the scope of this manual.

Although decades of scientific effort have gone into developing the diagnostic criteria sets for the disorders included in Section II, it is well recognized that this set of categorical diagnoses does not fully describe the full range of mental disorders that individuals experience and present to clinicians on a daily basis throughout the world. As noted previously in the introduction, the range of genetic/environmental interactions over the course of human development affecting cognitive, emotional and behavioral function is virtually limitless. As a result, it is impossible to capture the full range of psychopathology in the categorical diagnostic categories that we are now using. Hence, it is also necessary to include "other specified/unspecified" disorder options for presentations that do not fit exactly into the diagnostic boundaries of disorders in each chapter. In an emergency department setting, it may be possible to identify only the most prominent symptom expressions associated with a particular chapter—for example, delusions, hallucinations,

mania, depression, anxiety, substance intoxication, or neurocognitive symptoms—so that an "unspecified" disorder in that category is identified until a fuller differential diagnosis is possible.

Definition of a Mental Disorder

Each disorder identified in Section II of the manual (excluding those in the chapters entitled "Medication-Induced Movement Disorders and Other Adverse Effects of Medication" and "Other Conditions That May Be a Focus of Clinical Attention") must meet the definition of a mental disorder. Although no definition can capture all aspects of all disorders in the range contained in DSM-5, the following elements are required:

> A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

The diagnosis of a mental disorder should have clinical utility: it should help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients. However, the diagnosis of a mental disorder is not equivalent to a need for treatment. Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient's distress (mental pain) associated with the symptom(s), disability related to the patient's symptoms, risks and benefits of available treatments, and other factors (e.g., psychiatric symptoms complicating other illness). Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care. The fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care.

Approaches to validating diagnostic criteria for discrete categorical mental disorders have included the following types of evidence: antecedent validators (similar genetic markers, family traits, temperament, and environmental exposure), concurrent validators (similar neural substrates, biomarkers, emotional and cognitive processing, and symptom similarity), and predictive validators (similar clinical course and treatment response). In DSM-5, we recognize that the current diagnostic criteria for any single disorder will not necessarily identify a homogeneous group of patients who can be characterized reliably with all of these validators. Available evidence shows that these validators cross existing diagnostic boundaries but tend to congregate more frequently within and across adjacent DSM-5 chapter groups. Until incontrovertible etiological or pathophysiological mechanisms are identified to fully validate specific disorders or disorder spectra, the most important standard for the DSM-5 disorder criteria will be their clinical utility for the assessment of clinical course and treatment response of individuals grouped by a given set of diagnostic criteria.

This definition of mental disorder was developed for clinical, public health, and research purposes. Additional information is usually required beyond that contained in the DSM-5 diagnostic criteria in order to make legal judgments on such issues as criminal responsibility, eligibility for disability compensation, and competency (see "Cautionary Statement for Forensic Use of DSM-5" elsewhere in this manual).

Criterion for Clinical Significance

There have been substantial efforts by the DSM-5 Task Force and the World Health Organization (WHO) to separate the concepts of mental disorder and disability (impairment in social, occupational, or other important areas of functioning). In the WHO system, the International Classification of Diseases (ICD) covers all diseases and disorders, while the International Classification of Functioning, Disability and Health (ICF) provides a separate classification of global disability. The WHO Disability Assessment Schedule (WHODAS) is based on the ICF and has proven useful as a standardized measure of disability for mental disorders. However, in the absence of clear biological markers or clinically useful measurements of severity for many mental disorders, it has not been possible to completely separate normal and pathological symptom expressions contained in diagnostic criteria. This gap in information is particularly problematic in clinical situations in which the patient's symptom presentation by itself (particularly in mild forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of "mental disorder" would be inappropriate. Therefore, a generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning." The text following the revised definition of a mental disorder acknowledges that this criterion may be especially helpful in determining a patient's need for treatment. Use of information from family members and other third parties (in addition to the individual) regarding the individual's performance is recommended when necessary.

Elements of a Diagnosis

Diagnostic Criteria and Descriptors

Diagnostic criteria are offered as guidelines for making diagnoses, and their use should be informed by clinical judgment. Text descriptions, including introductory sections of each diagnostic chapter, can help support diagnosis (e.g., providing differential diagnoses; describing the criteria more fully under "Diagnostic Features").

Following the assessment of diagnostic criteria, clinicians should consider the application of disorder subtypes and/or specifiers as appropriate. Severity and course specifiers should be applied to denote the individual's current presentation, but only when the full criteria are met. When full criteria are not met, clinicians should consider whether the symptom presentation meets criteria for an "other specified" or "unspecified" designation. Where applicable, specific criteria for defining disorder severity (e.g., mild, moderate, severe, extreme), descriptive features (e.g., with good to fair insight; in a controlled environment), and course (e.g., in partial remission, in full remission, recurrent) are provided with each diagnosis. On the basis of the clinical interview, text descriptions, criteria, and clinician judgment, a final diagnosis is made.

The general convention in DSM-5 is to allow multiple diagnoses to be assigned for those presentations that meet criteria for more than one DSM-5 disorder.

Subtypes and Specifiers

Subtypes and specifiers (some of which are coded in the fourth, fifth, or sixth digit) are provided for increased specificity. *Subtypes* define mutually exclusive and jointly exhaustive phenomenological subgroupings within a diagnosis and are indicated by the instruction "*Specify* whether" in the criteria set. In contrast, *specifiers* are not intended to be mutually exclusive or jointly exhaustive, and as a consequence, more than one specifier may be given. Specifiers are indicated by the instruction "*Specify*" or "*Specify* if" in the criteria set. Specifiers provide an opportunity to define a more homogeneous subgrouping of

individuals with the disorder who share certain features (e.g., major depressive disorder, with mixed features) and to convey information that is relevant to the management of the individual's disorder, such as the "with other medical comorbidity" specifier in sleep-wake disorders. Although a fifth digit is sometimes assigned to code a subtype or specifier (e.g., 294.11 [F02.81] major neurocognitive disorder due to Alzheimer's disease, with behavioral disturbance) or severity (296.21 [F32.0] major depressive disorder, single episode, mild), the majority of subtypes and specifiers included in DSM-5 cannot be coded within the ICD-9-CM and ICD-10-CM systems and are indicated only by including the subtype or specifier after the name of the disorder (e.g., social anxiety disorder [social phobia], performance type). Note that in some cases, a specifier or subtype is codable in ICD-10-CM but not in ICD-9-CM. Accordingly, in some cases the 4th or 5th character codes for the subtypes or specifiers are provided only for the ICD-10-CM coding designations.

A DSM-5 diagnosis is usually applied to the individual's current presentation; previous diagnoses from which the individual has recovered should be clearly noted as such. Specifiers indicating *course* (e.g., in partial remission, in full remission) may be listed after the diagnosis and are indicated in a number of criteria sets. Where available, *severity specifiers* are provided to guide clinicians in rating the intensity, frequency, duration, symptom count, or other severity indicator of a disorder. Severity specifiers are indicated by the instruction "*Specify* current severity" in the criteria set and include disorder-specific definitions. *Descriptive features specifiers* have also been provided in the criteria set and convey additional information that can inform treatment planning (e.g., obsessive-compulsive disorder, with poor insight). Not all disorders include course, severity, and/or descriptive features specifiers.

Medication-Induced Movement Disorders and Other Conditions That May Be a Focus of Clinical Attention

In addition to important psychosocial and environmental factors (see "The Multiaxial System" in the "Introduction" elsewhere in this manual), these chapters in Section II also contain other conditions that are not mental disorders but may be encountered by mental health clinicians. These conditions may be listed as a reason for clinical visit in addition to, or in place of, the mental disorders listed in Section II. A separate chapter is devoted to medication-induced disorders and other adverse effects of medication that may be assessed and treated by clinicians in mental health practice such as akathisia, tardive dyskinesia, and dystonia. The description of neuroleptic malignant syndrome is expanded from that provided in DSM-IV-TR to highlight the emergent and potentially life-threatening nature of this condition, and a new entry on antidepressant discontinuation syndrome is provided. An additional chapter discusses other conditions that may be a focus of clinical attention. These include relational problems, problems related to abuse and neglect, problems with adherence to treatment regimens, obesity, antisocial behavior, and malingering.

Principal Diagnosis

When more than one diagnosis for an individual is given in an inpatient setting, the principal diagnosis is the condition established after study to be chiefly responsible for occasioning the admission of the individual. When more than one diagnosis is given for an individual in an outpatient setting, the reason for visit is the condition that is chiefly responsible for the ambulatory care medical services received during the visit. In most cases, the principal diagnosis or the reason for visit is also the main focus of attention or treatment. It is often difficult (and somewhat arbitrary) to determine which diagnosis is the principal diagnosis or the reason for visit, especially when, for example, a substance-related diagnosis such as alcohol use disorder is accompanied by a non-substance-related diagnosis such as schizophrenia. For example, it may be unclear which diagnosis should

be considered "principal" for an individual hospitalized with both schizophrenia and alcohol use disorder, because each condition may have contributed equally to the need for admission and treatment. The principal diagnosis is indicated by listing it first, and the remaining disorders are listed in order of focus of attention and treatment. When the principal diagnosis or reason for visit is a mental disorder due to another medical condition (e.g., major neurocognitive disorder due to Alzheimer's disease, psychotic disorder due to malignant lung neoplasm), ICD coding rules require that the etiological medical condition be listed first. In that case, the principal diagnosis or reason for visit would be the mental disorder due to the medical condition, the second listed diagnosis. In most cases, the disorder listed as the principal diagnosis or the reason for visit is followed by the qualifying phrase "(principal diagnosis)" or "(reason for visit)."

Provisional Diagnosis

The specifier "provisional" can be used when there is a strong presumption that the full criteria will ultimately be met for a disorder but not enough information is available to make a firm diagnosis. The clinician can indicate the diagnostic uncertainty by recording "(provisional)" following the diagnosis. For example, this diagnosis might be used when an individual who appears to have a major depressive disorder is unable to give an adequate history, and thus it cannot be established that the full criteria are met. Another use of the term *provisional* is for those situations in which differential diagnosis depends exclusively on the duration of illness. For example, a diagnosis of schizophreniform disorder requires a duration of less than 6 months but of at least 1 month and can only be given provisionally if assigned before remission has occurred.

Coding and Reporting Procedures

Each disorder is accompanied by an identifying diagnostic and statistical code, which is typically used by institutions and agencies for data collection and billing purposes. There are specific recording protocols for these diagnostic codes (identified as coding notes in the text) that were established by WHO, the U.S. Centers for Medicare and Medicaid Services (CMS), and the Centers for Disease Control and Prevention's National Center for Health Statistics to ensure consistent international recording of prevalence and mortality rates for identified health conditions. For most clinicians, the codes are used to identify the diagnosis or reason for visit for CMS and private insurance service claims. The official coding system in use in the United States as of publication of this manual is ICD-9-CM. Official adoption of ICD-10-CM is scheduled to take place on October 1, 2014, and these codes, which are shown parenthetically in this manual, should not be used until the official implementation occurs. Both ICD-9-CM and ICD-10-CM codes have been listed 1) preceding the name of the disorder in the classification and 2) accompanying the criteria set for each disorder. For some diagnoses (e.g., neurocognitive and substance/medication-induced disorders), the appropriate code depends on further specification and is listed within the criteria set for the disorder, as coding notes, and, in some cases, further clarified in a section on recording procedures. The names of some disorders are followed by alternative terms enclosed in parentheses, which, in most cases, were the DSM-IV names for the disorders.

Looking to the Future: Assessment and Monitoring Tools

The various components of DSM-5 are provided to facilitate patient assessment and to aid in developing a comprehensive case formulation. Whereas the diagnostic criteria in Section II are well-established measures that have undergone extensive review, the assess-

ment tools, a cultural formulation interview, and conditions for further study included in Section III are those for which we determined that the scientific evidence is not yet available to support widespread clinical use. These diagnostic aids and criteria are included to highlight the evolution and direction of scientific advances in these areas and to stimulate further research.

Each of the measures in Section III is provided to aid in a comprehensive assessment of individuals that will contribute to a diagnosis and treatment plan tailored to the individual presentation and clinical context. Where cultural dynamics are particularly important for diagnostic assessment, the cultural formulation interview should be considered as a useful aid to communication with the individual. Cross-cutting symptom and diagnosis-specific severity measures provide quantitative ratings of important clinical areas that are designed to be used at the initial evaluation to establish a baseline for comparison with ratings on subsequent encounters to monitor changes and inform treatment planning.

The use of such measures will undoubtedly be facilitated by digital applications, and the measures are included in Section III to provide for further evaluation and development. As with each DSM edition, the diagnostic criteria and the DSM-5 classification of mental disorders reflect the current consensus on the evolving knowledge in our field.

Cautionary Statement for Forensic Use of DSM-5

Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals. It is also important to note that DSM-5 does not provide treatment guidelines for any given disorder.

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations. For example, when the presence of a mental disorder is the predicate for a subsequent legal determination (e.g., involuntary civil commitment), the use of an established system of diagnosis enhances the value and reliability of the determination. By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders. The literature related to diagnoses also serves as a check on ungrounded speculation about mental disorders and about the functioning of a particular individual. Finally, diagnostic information about longitudinal course may improve decision making when the legal issue concerns an individual's mental functioning at a past or future point in time.

However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder such as intellectual disability (intellectual developmental disorder), schizophrenia, major neurocognitive disorder, gambling disorder, or pedophilic disorder does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.

Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised. Nonclinical decision makers should also be cautioned that a diagnosis does not carry any necessary implications regarding the etiology or causes of the individual's mental disorder or the individual's degree of control over behaviors that may be associated with the disorder. Even when diminished control over one's behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.

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SECTION II
Diagnostic Criteria and Codes

Neurodevelopmental Disorders 31
Schizophrenia Spectrum and Other Psychotic Disorders 87
Bipolar and Related Disorders 123
Depressive Disorders 155
Anxiety Disorders 189
Obsessive-Compulsive and Related Disorders 235
Trauma- and Stressor-Related Disorders 265
Dissociative Disorders 291
Somatic Symptom and Related Disorders 309
Feeding and Eating Disorders 329
Elimination Disorders 355
Sleep-Wake Disorders 361
Sexual Dysfunctions 423
Gender Dysphoria 451
Disruptive, Impulse-Control, and Conduct Disorders 461
Substance-Related and Addictive Disorders 481
Neurocognitive Disorders 591
Personality Disorders 645
Paraphilic Disorders 685
Other Mental Disorders 707
Medication-Induced Movement Disorders and Other Adverse Effects of Medication 709
Other Conditions That May Be a Focus of Clinical Attention 715

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This section contains the diagnostic criteria approved for routine clinical use along with the ICD-9-CM codes (ICD-10 codes are shown parenthetically). For each mental disorder, the diagnostic criteria are followed by descriptive text to assist in diagnostic decision making. Where needed, specific recording procedures are presented with the diagnostic criteria to provide guidance in selecting the most appropriate code. In some cases, separate recording procedures for ICD-9-CM and ICD-10-CM are provided. Although not considered as official DSM-5 disorders, medication-induced movement disorders and other adverse effects of medication, as well as other conditions that may be a focus of clinical attention (including additional ICD-9-CM V codes and forthcoming ICD-10-CM Z codes), are provided to indicate other reasons for a clinical visit such as environmental factors and relational problems. These codes are adapted from ICD-9-CM and ICD-10-CM and were neither reviewed nor approved as official DSM-5 diagnoses, but can provide additional context for a clinical formulation and treatment plan. These three components—the criteria and their descriptive text, the medication-induced movement disorders and other adverse effects of medication, and the descriptions of other conditions that may be a focus of clinical attention—represent the key elements of the clinical diagnostic process and thus are presented together.

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Neurodevelopmental Disorders

The neurodevelopmental disorders are a group of conditions with onset in the developmental period. The disorders typically manifest early in development, often before the child enters grade school, and are characterized by developmental deficits that produce impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from very specific limitations of learning or control of executive functions to global impairments of social skills or intelligence. The neurodevelopmental disorders frequently co-occur; for example, individuals with autism spectrum disorder often have intellectual disability (intellectual developmental disorder), and many children with attention-deficit/hyperactivity disorder (ADHD) also have a specific learning disorder. For some disorders, the clinical presentation includes symptoms of excess as well as deficits and delays in achieving expected milestones. For example, autism spectrum disorder is diagnosed only when the characteristic deficits of social communication are accompanied by excessively repetitive behaviors, restricted interests, and insistence on sameness.

Intellectual disability (intellectual developmental disorder) is characterized by deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience. The deficits result in impairments of adaptive functioning, such that the individual fails to meet standards of personal independence and social responsibility in one or more aspects of daily life, including communication, social participation, academic or occupational functioning, and personal independence at home or in community settings. Global developmental delay, as its name implies, is diagnosed when an individual fails to meet expected developmental milestones in several areas of intellectual functioning. The diagnosis is used for individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing. Intellectual disability may result from an acquired insult during the developmental period from, for example, a severe head injury, in which case a neurocognitive disorder also may be diagnosed.

The communication disorders include language disorder, speech sound disorder, social (pragmatic) communication disorder, and childhood-onset fluency disorder (stuttering). The first three disorders are characterized by deficits in the development and use of language, speech, and social communication, respectively. Childhood-onset fluency disorder is characterized by disturbances of the normal fluency and motor production of speech, including repetitive sounds or syllables, prolongation of consonants or vowel sounds, broken words, blocking, or words produced with an excess of physical tension. Like other neurodevelopmental disorders, communication disorders begin early in life and may produce lifelong functional impairments.

Autism spectrum disorder is characterized by persistent deficits in social communication and social interaction across multiple contexts, including deficits in social reciprocity, nonverbal communicative behaviors used for social interaction, and skills in developing, maintaining, and understanding relationships. In addition to the social communication deficits, the diagnosis of autism spectrum disorder requires the presence of restricted, repetitive patterns of behavior, interests, or activities. Because symptoms change with development and may be masked by compensatory mechanisms, the diagnostic criteria may

be met based on historical information, although the current presentation must cause significant impairment.

Within the diagnosis of autism spectrum disorder, individual clinical characteristics are noted through the use of specifiers (with or without accompanying intellectual impairment; with or without accompanying structural language impairment; associated with a known medical/genetic or environmental/acquired condition; associated with another neurodevelopmental, mental, or behavioral disorder), as well as specifiers that describe the autistic symptoms (age at first concern; with or without loss of established skills; severity). These specifiers provide clinicians with an opportunity to individualize the diagnosis and communicate a richer clinical description of the affected individuals. For example, many individuals previously diagnosed with Asperger's disorder would now receive a diagnosis of autism spectrum disorder without language or intellectual impairment.

ADHD is a neurodevelopmental disorder defined by impairing levels of inattention, disorganization, and/or hyperactivity-impulsivity. Inattention and disorganization entail inability to stay on task, seeming not to listen, and losing materials, at levels that are inconsistent with age or developmental level. Hyperactivity-impulsivity entails overactivity, fidgeting, inability to stay seated, intruding into other people's activities, and inability to wait—symptoms that are excessive for age or developmental level. In childhood, ADHD frequently overlaps with disorders that are often considered to be "externalizing disorders," such as oppositional defiant disorder and conduct disorder. ADHD often persists into adulthood, with resultant impairments of social, academic and occupational functioning.

The neurodevelopmental motor disorders include developmental coordination disorder, stereotypic movement disorder, and tic disorders. Developmental coordination disorder is characterized by deficits in the acquisition and execution of coordinated motor skills and is manifested by clumsiness and slowness or inaccuracy of performance of motor skills that cause interference with activities of daily living. Stereotypic movement disorder is diagnosed when an individual has repetitive, seemingly driven, and apparently purposeless motor behaviors, such as hand flapping, body rocking, head banging, self-biting, or hitting. The movements interfere with social, academic, or other activities. If the behaviors cause self-injury, this should be specified as part of the diagnostic description. Tic disorders are characterized by the presence of motor or vocal tics, which are sudden, rapid, recurrent, nonrhythmic, sterotyped motor movements or vocalizations. The duration, presumed etiology, and clinical presentation define the specific tic disorder that is diagnosed: Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, other specified tic disorder, and unspecified tic disorder. Tourette's disorder is diagnosed when the individual has multiple motor and vocal tics that have been present for at least 1 year and that have a waxing-waning symptom course.

Specific learning disorder, as the name implies, is diagnosed when there are specific deficits in an individual's ability to perceive or process information efficiently and accurately. This neurodevelopmental disorder first manifests during the years of formal schooling and is characterized by persistent and impairing difficulties with learning foundational academic skills in reading, writing, and/or math. The individual's performance of the affected academic skills is well below average for age, or acceptable performance levels are achieved only with extraordinary effort. Specific learning disorder may occur in individuals identified as intellectually gifted and manifest only when the learning demands or assessment procedures (e.g., timed tests) pose barriers that cannot be overcome by their innate intelligence and compensatory strategies. For all individuals, specific learning disorder can produce lifelong impairments in activities dependent on the skills, including occupational performance.

The use of specifiers for the neurodevelopmental disorder diagnoses enriches the clinical description of the individual's clinical course and current symptomatology. In addition to specifiers that describe the clinical presentation, such as age at onset or severity ratings, the neurodevelopmental disorders may include the specifier "associated with a known medical or genetic condition or environmental factor." This specifier gives clini-

cians an opportunity to document factors that may have played a role in the etiology of the disorder, as well as those that might affect the clinical course. Examples include genetic disorders, such as fragile X syndrome, tuberous sclerosis, and Rett syndrome; medical conditions such as epilepsy; and environmental factors, including very low birth weight and fetal alcohol exposure (even in the absence of stigmata of fetal alcohol syndrome).

Intellectual Disabilities

Intellectual Disability (Intellectual Developmental Disorder)

Diagnostic Criteria

Intellectual disability (intellectual developmental disorder) is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social, and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
B. Deficits in adaptive functioning that result in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.
C. Onset of intellectual and adaptive deficits during the developmental period.

Note: The diagnostic term *intellectual disability* is the equivalent term for the ICD-11 diagnosis of *intellectual developmental disorders.* Although the term *intellectual disability* is used throughout this manual, both terms are used in the title to clarify relationships with other classification systems. Moreover, a federal statute in the United States (Public Law 111-256, Rosa's Law) replaces the term *mental retardation* with *intellectual disability,* and research journals use the term *intellectual disability.* Thus, *intellectual disability* is the term in common use by medical, educational, and other professions and by the lay public and advocacy groups.

Specify current severity (see Table 1):

317 (F70) Mild
318.0 (F71) Moderate
318.1 (F72) Severe
318.2 (F73) Profound

Specifiers

The various levels of severity are defined on the basis of adaptive functioning, and not IQ scores, because it is adaptive functioning that determines the level of supports required. Moreover, IQ measures are less valid in the lower end of the IQ range.

TABLE 1 Severity levels for intellectual disability (intellectual developmental disorder)

Severity level	Conceptual domain	Social domain	Practical domain
Mild	For preschool children, there may be no obvious conceptual differences. For school-age children and adults, there are difficulties in learning academic skills involving reading, writing, arithmetic, time, or money, with support needed in one or more areas to meet age-related expectations. In adults, abstract thinking, executive function (i.e., planning, strategizing, priority setting, and cognitive flexibility), and short-term memory, as well as functional use of academic skills (e.g., reading, money management), are impaired. There is a somewhat concrete approach to problems and solutions compared with age-mates.	Compared with typically developing age-mates, the individual is immature in social interactions. For example, there may be difficulty in accurately perceiving peers' social cues. Communication, conversation, and language are more concrete or immature than expected for age. There may be difficulties regulating emotion and behavior in age-appropriate fashion; these difficulties are noticed by peers in social situations. There is limited understanding of risk in social situations; social judgment is immature for age, and the person is at risk of being manipulated by others (gullibility).	The individual may function age-appropriately in personal care. Individuals need some support with complex daily living tasks in comparison to peers. In adulthood, supports typically involve grocery shopping, transportation, home and child-care organizing, nutritious food preparation, and banking and money management. Recreational skills resemble those of age-mates, although judgment related to well-being and organization around recreation requires support. In adulthood, competitive employment is often seen in jobs that do not emphasize conceptual skills. Individuals generally need support to make health care decisions and legal decisions, and to learn to perform a skilled vocation competently. Support is typically needed to raise a family.

TABLE 1 Severity levels for intellectual disability (intellectual developmental disorder) *(continued)*

Severity level	Conceptual domain	Social domain	Practical domain
Moderate	All through development, the individual's conceptual skills lag markedly behind those of peers. For preschoolers, language and pre-academic skills develop slowly. For school-age children, progress in reading, writing, mathematics, and understanding of time and money occurs slowly across the school years and is markedly limited compared with that of peers. For adults, academic skill development is typically at an elementary level, and support is required for all use of academic skills in work and personal life. Ongoing assistance on a daily basis is needed to complete conceptual tasks of day-to-day life, and others may take over these responsibilities fully for the individual.	The individual shows marked differences from peers in social and communicative behavior across development. Spoken language is typically a primary tool for social communication but is much less complex than that of peers. Capacity for relationships is evident in ties to family and friends, and the individual may have successful friendships across life and sometimes romantic relations in adulthood. However, individuals may not perceive or interpret social cues accurately. Social judgment and decision-making abilities are limited, and caretakers must assist the person with life decisions. Friendships with typically developing peers are often affected by communication or social limitations. Significant social and communicative support is needed in work settings for success.	The individual can care for personal needs involving eating, dressing, elimination, and hygiene as an adult, although an extended period of teaching and time is needed for the individual to become independent in these areas, and reminders may be needed. Similarly, participation in all household tasks can be achieved by adulthood, although an extended period of teaching is needed, and ongoing supports will typically occur for adult-level performance. Independent employment in jobs that require limited conceptual and communication skills can be achieved, but considerable support from co-workers, supervisors, and others is needed to manage social expectations, job complexities, and ancillary responsibilities such as scheduling, transportation, health benefits, and money management. A variety of recreational skills can be developed. These typically require additional supports and learning opportunities over an extended period of time. Maladaptive behavior is present in a significant minority and causes social problems.

TABLE 1 Severity levels for intellectual disability (intellectual developmental disorder) *(continued)*

Severity level	Conceptual domain	Social domain	Practical domain
Severe	Attainment of conceptual skills is limited. The individual generally has little understanding of written language or of concepts involving numbers, quantity, time, and money. Caretakers provide extensive supports for problem solving throughout life.	Spoken language is quite limited in terms of vocabulary and grammar. Speech may be single words or phrases and may be supplemented through augmentative means. Speech and communication are focused on the here and now within everyday events. Language is used for social communication more than for explication. Individuals understand simple speech and gestural communication. Relationships with family members and familiar others are a source of pleasure and help.	The individual requires support for all activities of daily living, including meals, dressing, bathing, and elimination. The individual requires supervision at all times. The individual cannot make responsible decisions regarding well-being of self or others. In adulthood, participation in tasks at home, recreation, and work requires ongoing support and assistance. Skill acquisition in all domains involves long-term teaching and ongoing support. Maladaptive behavior, including self-injury, is present in a significant minority.
Profound	Conceptual skills generally involve the physical world rather than symbolic processes. The individual may use objects in goal-directed fashion for self-care, work, and recreation. Certain visuospatial skills, such as matching and sorting based on physical characteristics, may be acquired. However, co-occurring motor and sensory impairments may prevent functional use of objects.	The individual has very limited understanding of symbolic communication in speech or gesture. He or she may understand some simple instructions or gestures. The individual expresses his or her own desires and emotions largely through nonverbal, nonsymbolic communication. The individual enjoys relationships with well-known family members, caretakers, and familiar others, and initiates and responds to social interactions through gestural and emotional cues. Co-occurring sensory and physical impairments may prevent many social activities.	The individual is dependent on others for all aspects of daily physical care, health, and safety, although he or she may be able to participate in some of these activities as well. Individuals without severe physical impairments may assist with some daily work tasks at home, like carrying dishes to the table. Simple actions with objects may be the basis of participation in some vocational activities with high levels of ongoing support. Recreational activities may involve, for example, enjoyment in listening to music, watching movies, going out for walks, or participating in water activities, all with the support of others. Co-occurring physical and sensory impairments are frequent barriers to participation (beyond watching) in home, recreational, and vocational activities. Maladaptive behavior is present in a significant minority.

Diagnostic Features

The essential features of intellectual disability (intellectual developmental disorder) are deficits in general mental abilities (Criterion A) and impairment in everyday adaptive functioning, in comparison to an individual's age-, gender-, and socioculturally matched peers (Criterion B). Onset is during the developmental period (Criterion C). The diagnosis of intellectual disability is based on both clinical assessment and standardized testing of intellectual and adaptive functions.

Criterion A refers to intellectual functions that involve reasoning, problem solving, planning, abstract thinking, judgment, learning from instruction and experience, and practical understanding. Critical components include verbal comprehension, working memory, perceptual reasoning, quantitative reasoning, abstract thought, and cognitive efficacy. Intellectual functioning is typically measured with individually administered and psychometrically valid, comprehensive, culturally appropriate, psychometrically sound tests of intelligence. Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65–75 (70 ± 5). Clinical training and judgment are required to interpret test results and assess intellectual performance.

Factors that may affect test scores include practice effects and the "Flynn effect' (i.e., overly high scores due to out-of-date test norms). Invalid scores may result from the use of brief intelligence screening tests or group tests; highly discrepant individual subtest scores may make an overall IQ score invalid. Instruments must be normed for the individual's sociocultural background and native language. Co-occurring disorders that affect communication, language, and/or motor or sensory function may affect test scores. Individual cognitive profiles based on neuropsychological testing are more useful for understanding intellectual abilities than a single IQ score. Such testing may identify areas of relative strengths and weaknesses, an assessment important for academic and vocational planning.

IQ test scores are approximations of conceptual functioning but may be insufficient to assess reasoning in real-life situations and mastery of practical tasks. For example, a person with an IQ score above 70 may have such severe adaptive behavior problems in social judgment, social understanding, and other areas of adaptive functioning that the person's actual functioning is comparable to that of individuals with a lower IQ score. Thus, clinical judgment is needed in interpreting the results of IQ tests.

Deficits in adaptive functioning (Criterion B) refer to how well a person meets community standards of personal independence and social responsibility, in comparison to others of similar age and sociocultural background. Adaptive functioning involves adaptive reasoning in three domains: conceptual, social, and practical. The *conceptual (academic) domain* involves competence in memory, language, reading, writing, math reasoning, acquisition of practical knowledge, problem solving, and judgment in novel situations, among others. The *social domain* involves awareness of others' thoughts, feelings, and experiences; empathy; interpersonal communication skills; friendship abilities; and social judgment, among others. The *practical domain* involves learning and self-management across life settings, including personal care, job responsibilities, money management, recreation, self-management of behavior, and school and work task organization, among others. Intellectual capacity, education, motivation, socialization, personality features, vocational opportunity, cultural experience, and coexisting general medical conditions or mental disorders influence adaptive functioning.

Adaptive functioning is assessed using both clinical evaluation and individualized, culturally appropriate, psychometrically sound measures. Standardized measures are used with knowledgeable informants (e.g., parent or other family member; teacher; counselor; care provider) and the individual to the extent possible. Additional sources of information include educational, developmental, medical, and mental health evaluations. Scores from standardized measures and interview sources must be interpreted using clinical judgment. When standardized testing is difficult or impossible, because of a variety of

factors (e.g., sensory impairment, severe problem behavior), the individual may be diagnosed with unspecified intellectual disability. Adaptive functioning may be difficult to assess in a controlled setting (e.g., prisons, detention centers); if possible, corroborative information reflecting functioning outside those settings should be obtained.

Criterion B is met when at least one domain of adaptive functioning—conceptual, social, or practical—is sufficiently impaired that ongoing support is needed in order for the person to perform adequately in one or more life settings at school, at work, at home, or in the community. To meet diagnostic criteria for intellectual disability, the deficits in adaptive functioning must be directly related to the intellectual impairments described in Criterion A. Criterion C, onset during the developmental period, refers to recognition that intellectual and adaptive deficits are present during childhood or adolescence.

Associated Features Supporting Diagnosis

Intellectual disability is a heterogeneous condition with multiple causes. There may be associated difficulties with social judgment; assessment of risk; self-management of behavior, emotions, or interpersonal relationships; or motivation in school or work environments. Lack of communication skills may predispose to disruptive and aggressive behaviors. Gullibility is often a feature, involving naiveté in social situations and a tendency for being easily led by others. Gullibility and lack of awareness of risk may result in exploitation by others and possible victimization, fraud, unintentional criminal involvement, false confessions, and risk for physical and sexual abuse. These associated features can be important in criminal cases, including Atkins-type hearings involving the death penalty.

Individuals with a diagnosis of intellectual disability with co-occurring mental disorders are at risk for suicide. They think about suicide, make suicide attempts, and may die from them. Thus, screening for suicidal thoughts is essential in the assessment process. Because of a lack of awareness of risk and danger, accidental injury rates may be increased.

Prevalence

Intellectual disability has an overall general population prevalence of approximately 1%, and prevalence rates vary by age. Prevalence for severe intellectual disability is approximately 6 per 1,000.

Development and Course

Onset of intellectual disability is in the developmental period. The age and characteristic features at onset depend on the etiology and severity of brain dysfunction. Delayed motor, language, and social milestones may be identifiable within the first 2 years of life among those with more severe intellectual disability, while mild levels may not be identifiable until school age when difficulty with academic learning becomes apparent. All criteria (including Criterion C) must be fulfilled by history or current presentation. Some children under age 5 years whose presentation will eventually meet criteria for intellectual disability have deficits that meet criteria for global developmental delay.

When intellectual disability is associated with a genetic syndrome, there may be a characteristic physical appearance (as in, e.g., Down syndrome). Some syndromes have a *behavioral phenotype*, which refers to specific behaviors that are characteristic of particular genetic disorder (e.g., Lesch-Nyhan syndrome). In acquired forms, the onset may be abrupt following an illness such as meningitis or encephalitis or head trauma occurring during the developmental period. When intellectual disability results from a loss of previously acquired cognitive skills, as in severe traumatic brain injury, the diagnoses of intellectual disability and of a neurocognitive disorder may both be assigned.

Although intellectual disability is generally nonprogressive, in certain genetic disorders (e.g., Rett syndrome) there are periods of worsening, followed by stabilization, and in

others (e.g., San Phillippo syndrome) progressive worsening of intellectual function. After early childhood, the disorder is generally lifelong, although severity levels may change over time. The course may be influenced by underlying medical or genetic conditions and co-occurring conditions (e.g., hearing or visual impairments, epilepsy). Early and ongoing interventions may improve adaptive functioning throughout childhood and adulthood. In some cases, these result in significant improvement of intellectual functioning, such that the diagnosis of intellectual disability is no longer appropriate. Thus, it is common practice when assessing infants and young children to delay diagnosis of intellectual disability until after an appropriate course of intervention is provided. For older children and adults, the extent of support provided may allow for full participation in all activities of daily living and improved adaptive function. Diagnostic assessments must determine whether improved adaptive skills are the result of a stable, generalized new skill acquisition (in which case the diagnosis of intellectual disability may no longer be appropriate) or whether the improvement is contingent on the presence of supports and ongoing interventions (in which case the diagnosis of intellectual disability may still be appropriate).

Risk and Prognostic Factors

Genetic and physiological. Prenatal etiologies include genetic syndromes (e.g., sequence variations or copy number variants involving one or more genes; chromosomal disorders), inborn errors of metabolism, brain malformations, maternal disease (including placental disease), and environmental influences (e.g., alcohol, other drugs, toxins, teratogens). Perinatal causes include a variety of labor and delivery-related events leading to neonatal encephalopathy. Postnatal causes include hypoxic ischemic injury, traumatic brain injury, infections, demyelinating disorders, seizure disorders (e.g., infantile spasms), severe and chronic social deprivation, and toxic metabolic syndromes and intoxications (e.g., lead, mercury).

Culture-Related Diagnostic Issues

Intellectual disability occurs in all races and cultures. Cultural sensitivity and knowledge are needed during assessment, and the individual's ethnic, cultural, and linguistic background, available experiences, and adaptive functioning within his or her community and cultural setting must be taken into account.

Gender-Related Diagnostic Issues

Overall, males are more likely than females to be diagnosed with both mild (average male:female ratio 1.6:1) and severe (average male:female ratio 1.2:1) forms of intellectual disability. However, gender ratios vary widely in reported studies. Sex-linked genetic factors and male vulnerability to brain insult may account for some of the gender differences.

Diagnostic Markers

A comprehensive evaluation includes an assessment of intellectual capacity and adaptive functioning; identification of genetic and nongenetic etiologies; evaluation for associated medical conditions (e.g., cerebral palsy, seizure disorder); and evaluation for co-occurring mental, emotional, and behavioral disorders. Components of the evaluation may include basic pre- and perinatal medical history, three-generational family pedigree, physical examination, genetic evaluation (e.g., karyotype or chromosomal microarray analysis and testing for specific genetic syndromes), and metabolic screening and neuroimaging assessment.

Differential Diagnosis

The diagnosis of intellectual disability should be made whenever Criteria A, B, and C are met. A diagnosis of intellectual disability should not be assumed because of a particular

genetic or medical condition. A genetic syndrome linked to intellectual disability should be noted as a concurrent diagnosis with the intellectual disability.

Major and mild neurocognitive disorders. Intellectual disability is categorized as a neurodevelopmental disorder and is distinct from the neurocognitive disorders, which are characterized by a loss of cognitive functioning. Major neurocognitive disorder may co-occur with intellectual disability (e.g., an individual with Down syndrome who develops Alzheimer's disease, or an individual with intellectual disability who loses further cognitive capacity following a head injury). In such cases, the diagnoses of intellectual disability and neurocognitive disorder may both be given.

Communication disorders and specific learning disorder. These neurodevelopmental disorders are specific to the communication and learning domains and do not show deficits in intellectual and adaptive behavior. They may co-occur with intellectual disability. Both diagnoses are made if full criteria are met for intellectual disability and a communication disorder or specific learning disorder.

Autism spectrum disorder. Intellectual disability is common among individuals with autism spectrum disorder. Assessment of intellectual ability may be complicated by social-communication and behavior deficits inherent to autism spectrum disorder, which may interfere with understanding and complying with test procedures. Appropriate assessment of intellectual functioning in autism spectrum disorder is essential, with reassessment across the developmental period, because IQ scores in autism spectrum disorder may be unstable, particularly in early childhood.

Comorbidity

Co-occurring mental, neurodevelopmental, medical, and physical conditions are frequent in intellectual disability, with rates of some conditions (e.g., mental disorders, cerebral palsy, and epilepsy) three to four times higher than in the general population. The prognosis and outcome of co-occurring diagnoses may be influenced by the presence of intellectual disability. Assessment procedures may require modifications because of associated disorders, including communication disorders, autism spectrum disorder, and motor, sensory, or other disorders. Knowledgeable informants are essential for identifying symptoms such as irritability, mood dysregulation, aggression, eating problems, and sleep problems, and for assessing adaptive functioning in various community settings.

The most common co-occurring mental and neurodevelopmental disorders are attention-deficit/hyperactivity disorder; depressive and bipolar disorders; anxiety disorders; autism spectrum disorder; stereotypic movement disorder (with or without self-injurious behavior); impulse-control disorders; and major neurocognitive disorder. Major depressive disorder may occur throughout the range of severity of intellectual disability. Self-injurious behavior requires prompt diagnostic attention and may warrant a separate diagnosis of stereotypic movement disorder. Individuals with intellectual disability, particularly those with more severe intellectual disability, may also exhibit aggression and disruptive behaviors, including harm of others or property destruction.

Relationship to Other Classifications

ICD-11 (in development at the time of this publication) uses the term *intellectual developmental disorders* to indicate that these are disorders that involve impaired brain functioning early in life. These disorders are described in ICD-11 as a metasyndrome occurring in the developmental period analogous to dementia or neurocognitive disorder in later life. There are four subtypes in ICD-11: mild, moderate, severe, and profound.

The American Association on Intellectual and Developmental Disabilities (AAIDD) also uses the term *intellectual disability* with a similar meaning to the term as used in this

manual. The AAIDD's classification is multidimensional rather than categorical and is based on the disability construct. Rather than listing specifiers as is done in DSM-5, the AAIDD emphasizes a profile of supports based on severity.

Global Developmental Delay

315.8 (F88)

This diagnosis is reserved for individuals *under* the age of 5 years when the clinical severity level cannot be reliably assessed during early childhood. This category is diagnosed when an individual fails to meet expected developmental milestones in several areas of intellectual functioning, and applies to individuals who are unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing. This category requires reassessment after a period of time.

Unspecified Intellectual Disability (Intellectual Developmental Disorder)

319 (F79)

This category is reserved for individuals *over* the age of 5 years when assessment of the degree of intellectual disability (intellectual developmental disorder) by means of locally available procedures is rendered difficult or impossible because of associated sensory or physical impairments, as in blindness or prelingual deafness; locomotor disability; or presence of severe problem behaviors or co-occurring mental disorder. This category should only be used in exceptional circumstances and requires reassessment after a period of time.

Communication Disorders

Disorders of communication include deficits in language, speech, and communication. *Speech* is the expressive production of sounds and includes an individual's articulation, fluency, voice, and resonance quality. *Language* includes the form, function, and use of a conventional system of symbols (i.e., spoken words, sign language, written words, pictures) in a rule-governed manner for communication. *Communication* includes any verbal or nonverbal behavior (whether intentional or unintentional) that influences the behavior, ideas, or attitudes of another individual. Assessments of speech, language and communication abilities must take into account the individual's cultural and language context, particularly for individuals growing up in bilingual environments. The standardized measures of language development and of nonverbal intellectual capacity must be relevant for the cultural and linguistic group (i.e., tests developed and standardized for one group may not provide appropriate norms for a different group). The diagnostic category of communication disorders includes the following: language disorder, speech sound disorder, childhood-onset fluency disorder (stuttering), social (pragmatic) communication disorder, and other specified and unspecified communication disorders.

Language Disorder

Diagnostic Criteria **315.32 (F80.2)**

A. Persistent difficulties in the acquisition and use of language across modalities (i.e., spoken, written, sign language, or other) due to deficits in comprehension or production that include the following:
   1. Reduced vocabulary (word knowledge and use).
   2. Limited sentence structure (ability to put words and word endings together to form sentences based on the rules of grammar and morphology).
   3. Impairments in discourse (ability to use vocabulary and connect sentences to explain or describe a topic or series of events or have a conversation).

B. Language abilities are substantially and quantifiably below those expected for age, resulting in functional limitations in effective communication, social participation, academic achievement, or occupational performance, individually or in any combination.

C. Onset of symptoms is in the early developmental period.

D. The difficulties are not attributable to hearing or other sensory impairment, motor dysfunction, or another medical or neurological condition and are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay.

Diagnostic Features

The core diagnostic features of language disorder are difficulties in the acquisition and use of language due to deficits in the comprehension or production of vocabulary, sentence structure, and discourse. The language deficits are evident in spoken communication, written communication, or sign language. Language learning and use is dependent on both receptive and expressive skills. *Expressive ability* refers to the production of vocal, gestural, or verbal signals, while *receptive ability* refers to the process of receiving and comprehending language messages. Language skills need to be assessed in both expressive and receptive modalities as these may differ in severity. For example, an individual's expressive language may be severely impaired, while his receptive language is hardly impaired at all.

Language disorder usually affects vocabulary and grammar, and these effects then limit the capacity for discourse. The child's first words and phrases are likely to be delayed in onset; vocabulary size is smaller and less varied than expected; and sentences are shorter and less complex with grammatical errors, especially in past tense. Deficits in comprehension of language are frequently underestimated, as children may be good at using context to infer meaning. There may be word-finding problems, impoverished verbal definitions, or poor understanding of synonyms, multiple meanings, or word play appropriate for age and culture. Problems with remembering new words and sentences are manifested by difficulties following instructions of increasing length, difficulties rehearsing strings of verbal information (e.g., remembering a phone number or a shopping list), and difficulties remembering novel sound sequences, a skill that may be important for learning new words. Difficulties with discourse are shown by a reduced ability to provide adequate information about the key events and to narrate a coherent story.

The language difficulty is manifest by abilities substantially and quantifiably below that expected for age and significantly interfering with academic achievement, occupational performance, effective communication, or socialization (Criterion B). A diagnosis of language disorder is made based on the synthesis of the individual's history, direct clinical observation in different contexts (i.e., home, school, or work), and scores from standardized tests of language ability that can be used to guide estimates of severity.

Associated Features Supporting Diagnosis

A positive family history of language disorders is often present. Individuals, even children, can be adept at accommodating to their limited language. They may appear to be shy or reticent to talk. Affected individuals may prefer to communicate only with family members or other familiar individuals. Although these social indicators are not diagnostic of a language disorder, if they are notable and persistent, they warrant referral for a full language assessment. Language disorder, particularly expressive deficits, may co-occur with speech sound disorder.

Development and Course

Language acquisition is marked by changes from onset in toddlerhood to the adult level of competency that appears during adolescence. Changes appear across the dimensions of language (sounds, words, grammar, narratives/expository texts, and conversational skills) in age-graded increments and synchronies. Language disorder emerges during the early developmental period; however, there is considerable variation in early vocabulary acquisition and early word combinations, and individual differences are not, as single indicators, highly predictive of later outcomes. By age 4 years, individual differences in language ability are more stable, with better measurement accuracy, and are highly predictive of later outcomes. Language disorder diagnosed from 4 years of age is likely to be stable over time and typically persists into adulthood, although the particular profile of language strengths and deficits is likely to change over the course of development.

Risk and Prognostic Factors

Children with receptive language impairments have a poorer prognosis than those with predominantly expressive impairments. They are more resistant to treatment, and difficulties with reading comprehension are frequently seen.

Genetic and physiological. Language disorders are highly heritable, and family members are more likely to have a history of language impairment.

Differential Diagnosis

Normal variations in language. Language disorder needs to be distinguished from normal developmental variations, and this distinction may be difficult to make before 4 years of age. Regional, social, or cultural/ethnic variations of language (e.g., dialects) must be considered when an individual is being assessed for language impairment.

Hearing or other sensory impairment. Hearing impairment needs to be excluded as the primary cause of language difficulties. Language deficits may be associated with a hearing impairment, other sensory deficit, or a speech-motor deficit. When language deficits are in excess of those usually associated with these problems, a diagnosis of language disorder may be made.

Intellectual disability (intellectual developmental disorder). Language delay is often the presenting feature of intellectual disability, and the definitive diagnosis may not be made until the child is able to complete standardized assessments. A separate diagnosis is not given unless the language deficits are clearly in excess of the intellectual limitations.

Neurological disorders. Language disorder can be acquired in association with neurological disorders, including epilepsy (e.g., acquired aphasia or Landau-Kleffner syndrome).

Language regression. Loss of speech and language in a child younger than 3 years may be a sign of autism spectrum disorder (with developmental regression) or a specific neurological condition, such as Landau-Kleffner syndrome. Among children older than 3 years, language loss may be a symptom of seizures, and a diagnostic assessment is necessary to exclude the presence of epilepsy (e.g., routine and sleep electroencephalogram).

Comorbidity

Language disorder is strongly associated with other neurodevelopmental disorders in terms of specific learning disorder (literacy and numeracy), attention-deficit/hyperactivity disorder, autism spectrum disorder, and developmental coordination disorder. It is also associated with social (pragmatic) communication disorder. A positive family history of speech or language disorders is often present.

Speech Sound Disorder

Diagnostic Criteria **315.39 (F80.0)**

A. Persistent difficulty with speech sound production that interferes with speech intelligibility or prevents verbal communication of messages.
B. The disturbance causes limitations in effective communication that interfere with social participation, academic achievement, or occupational performance, individually or in any combination.
C. Onset of symptoms is in the early developmental period.
D. The difficulties are not attributable to congenital or acquired conditions, such as cerebral palsy, cleft palate, deafness or hearing loss, traumatic brain injury, or other medical or neurological conditions.

Diagnostic Features

Speech sound production describes the clear articulation of the phonemes (i.e., individual sounds) that in combination make up spoken words. Speech sound production requires both the phonological knowledge of speech sounds and the ability to coordinate the movements of the articulators (i.e., the jaw, tongue, and lips,) with breathing and vocalizing for speech. Children with speech production difficulties may experience difficulty with phonological knowledge of speech sounds or the ability to coordinate movements for speech in varying degrees. Speech sound disorder is thus heterogeneous in its underlying mechanisms and includes phonological disorder and articulation disorder. A speech sound disorder is diagnosed when speech sound production is not what would be expected based on the child's age and developmental stage and when the deficits are not the result of a physical, structural, neurological, or hearing impairment. Among typically developing children at age 4 years, overall speech should be intelligible, whereas at age 2 years, only 50% may be understandable.

Associated Features Supporting Diagnosis

Language disorder, particularly expressive deficits, may be found to co-occur with speech sound disorder. A positive family history of speech or language disorders is often present.

If the ability to rapidly coordinate the articulators is a particular aspect of difficulty, there may be a history of delay or incoordination in acquiring skills that also utilize the articulators and related facial musculature; among others, these skills include chewing, maintaining mouth closure, and blowing the nose. Other areas of motor coordination may be impaired as in developmental coordination disorder. *Verbal dyspraxia* is a term also used for speech production problems.

Speech may be differentially impaired in certain genetic conditions (e.g., Down syndrome, 22q deletion, *FoxP2* gene mutation). If present, these should also be coded.

Development and Course

Learning to produce speech sounds clearly and accurately and learning to produce connected speech fluently are developmental skills. Articulation of speech sounds follows a

developmental pattern, which is reflected in the age norms of standardized tests. It is not unusual for typically developing children to use developmental processes for shortening words and syllables as they are learning to talk, but their progression in mastering speech sound production should result in mostly intelligible speech by age 3 years. Children with speech sound disorder continue to use immature phonological simplification processes past the age when most children can produce words clearly.

Most speech sounds should be produced clearly and most words should be pronounced accurately according to age and community norms by age 7 years. The most frequently misarticulated sounds also tend to be learned later, leading them to be called the "late eight" (*l, r, s, z, th, ch, dzh,* and *zh*). Misarticulation of any of these sounds by itself could be considered within normal limits up to age 8 years. When multiple sounds are involved, it may be appropriate to target some of those sounds as part of a plan to improve intelligibility prior to the age at which almost all children can produce them accurately. Lisping (i.e., misarticulating sibilants) is particularly common and may involve frontal or lateral patterns of airstream direction. It may be associated with an abnormal tongue-thrust swallowing pattern.

Most children with speech sound disorder respond well to treatment, and speech difficulties improve over time, and thus the disorder may not be lifelong. However, when a language disorder is also present, the speech disorder has a poorer prognosis and may be associated with specific learning disorders.

Differential Diagnosis

Normal variations in speech. Regional, social, or cultural/ethnic variations of speech should be considered before making the diagnosis.

Hearing or other sensory impairment. Hearing impairment or deafness may result in abnormalities of speech. Deficits of speech sound production may be associated with a hearing impairment, other sensory deficit, or a speech-motor deficit. When speech deficits are in excess of those usually associated with these problems, a diagnosis of speech sound disorder may be made.

Structural deficits. Speech impairment may be due to structural deficits (e.g., cleft palate).

Dysarthria. Speech impairment may be attributable to a motor disorder, such as cerebral palsy. Neurological signs, as well as distinctive features of voice, differentiate dysarthria from speech sound disorder, although in young children (under 3 years) differentiation may be difficult, particularly when there is no or minimal general body motor involvement (as in, e.g., Worster-Drought syndrome).

Selective mutism. Limited use of speech may be a sign of selective mutism, an anxiety disorder that is characterized by a lack of speech in one or more contexts or settings. Selective mutism may develop in children with a speech disorder because of embarassment about their impairments, but many children with selective mutism exhibit normal speech in "safe" settings, such as at home or with close friends.

Childhood-Onset Fluency Disorder (Stuttering)

Diagnostic Criteria **315.35 (F80.81)**

A. Disturbances in the normal fluency and time patterning of speech that are inappropriate for the individual's age and language skills, persist over time, and are characterized by frequent and marked occurrences of one (or more) of the following:

   1. Sound and syllable repetitions.
   2. Sound prolongations of consonants as well as vowels.

3. Broken words (e.g., pauses within a word).
4. Audible or silent blocking (filled or unfilled pauses in speech).
5. Circumlocutions (word substitutions to avoid problematic words).
6. Words produced with an excess of physical tension.
7. Monosyllabic whole-word repetitions (e.g., "I-I-I-I see him").

B. The disturbance causes anxiety about speaking or limitations in effective communication, social participation, or academic or occupational performance, individually or in any combination.

C. The onset of symptoms is in the early developmental period. (**Note:** Later-onset cases are diagnosed as 307.0 [F98.5] adult-onset fluency disorder.)

D. The disturbance is not attributable to a speech-motor or sensory deficit, dysfluency associated with neurological insult (e.g., stroke, tumor, trauma), or another medical condition and is not better explained by another mental disorder.

Diagnostic Features

The essential feature of childhood-onset fluency disorder (stuttering) is a disturbance in the normal fluency and time patterning of speech that is inappropriate for the individual's age. This disturbance is characterized by frequent repetitions or prolongations of sounds or syllables and by other types of speech dysfluencies, including broken words (e.g., pauses within a word), audible or silent blocking (i.e., filled or unfilled pauses in speech), circumlocutions (i.e., word substitutions to avoid problematic words), words produced with an excess of physical tension, and monosyllabic whole-word repetitions (e.g., "I-I-I-I see him"). The disturbance in fluency interferes with academic or occupational achievement or with social communication. The extent of the disturbance varies from situation to situation and often is more severe when there is special pressure to communicate (e.g., giving a report at school, interviewing for a job). Dysfluency is often absent during oral reading, singing, or talking to inanimate objects or to pets.

Associated Features Supporting Diagnosis

Fearful anticipation of the problem may develop. The speaker may attempt to avoid dysfluencies by linguistic mechanisms (e.g., altering the rate of speech, avoiding certain words or sounds) or by avoiding certain speech situations, such as telephoning or public speaking. In addition to being features of the condition, stress and anxiety have been shown to exacerbate dysfluency.

Childhood-onset fluency disorder may also be accompanied by motor movements (e.g., eye blinks, tics, tremors of the lips or face, jerking of the head, breathing movements, fist clenching). Children with fluency disorder show a range of language abilities, and the relationship between fluency disorder and language abilities is unclear.

Development and Course

Childhood-onset fluency disorder, or developmental stuttering, occurs by age 6 for 80%–90% of affected individuals, with age at onset ranging from 2 to 7 years. The onset can be insidious or more sudden. Typically, dysfluencies start gradually, with repetition of initial consonants, first words of a phrase, or long words. The child may not be aware of dysfluencies. As the disorder progresses, the dysfluencies become more frequent and interfering, occurring on the most meaningful words or phrases in the utterance. As the child becomes aware of the speech difficulty, he or she may develop mechanisms for avoiding the dysfluencies and emotional responses, including avoidance of public speaking and use of short and simple utterances. Longitudinal research shows that 65%–85% of children re-

cover from the dysfluency, with severity of fluency disorder at age 8 years predicting recovery or persistence into adolescence and beyond.

Risk and Prognostic Factors

Genetic and physiological. The risk of stuttering among first-degree biological relatives of individuals with childhood-onset fluency disorder is more than three times the risk in the general population.

Functional Consequences of Childhood-Onset Fluency Disorder (Stuttering)

In addition to being features of the condition, stress and anxiety can exacerbate dysfluency. Impairment of social functioning may result from this anxiety.

Differential Diagnosis

Sensory deficits. Dysfluencies of speech may be associated with a hearing impairment or other sensory deficit or a speech-motor deficit. When the speech dysfluencies are in excess of those usually associated with these problems, a diagnosis of childhood-onset fluency disorder may be made.

Normal speech dysfluencies. The disorder must be distinguished from normal dysfluencies that occur frequently in young children, which include whole-word or phrase repetitions (e.g., "I want, I want ice cream"), incomplete phrases, interjections, unfilled pauses, and parenthetical remarks. If these difficulties increase in frequency or complexity as the child grows older, a diagnosis of childhood-onset fluency disorder is appropriate.

Medication side effects. Stuttering may occur as a side effect of medication and may be detected by a temporal relationship with exposure to the medication.

Adult-onset dysfluencies. If onset of dysfluencies is during or after adolescence, it is an "adult-onset dysfluency" rather than a neurodevelopmental disorder. Adult-onset dysfluencies are associated with specific neurological insults and a variety of medical conditions and mental disorders and may be specified with them, but they are not a DSM-5 diagnosis.

Tourette's disorder. Vocal tics and repetitive vocalizations of Tourette's disorder should be distinguishable from the repetitive sounds of childhood-onset fluency disorder by their nature and timing.

Social (Pragmatic) Communication Disorder

Diagnostic Criteria **315.39 (F80.89)**

A. Persistent difficulties in the social use of verbal and nonverbal communication as manifested by all of the following:

1. Deficits in using communication for social purposes, such as greeting and sharing information, in a manner that is appropriate for the social context.
2. Impairment of the ability to change communication to match context or the needs of the listener, such as speaking differently in a classroom than on a playground, talking differently to a child than to an adult, and avoiding use of overly formal language.
3. Difficulties following rules for conversation and storytelling, such as taking turns in conversation, rephrasing when misunderstood, and knowing how to use verbal and nonverbal signals to regulate interaction.

4. Difficulties understanding what is not explicitly stated (e.g., making inferences) and nonliteral or ambiguous meanings of language (e.g., idioms, humor, metaphors, multiple meanings that depend on the context for interpretation).

B. The deficits result in functional limitations in effective communication, social participation, social relationships, academic achievement, or occupational performance, individually or in combination.

C. The onset of the symptoms is in the early developmental period (but deficits may not become fully manifest until social communication demands exceed limited capacities).

D. The symptoms are not attributable to another medical or neurological condition or to low abilities in the domains of word structure and grammar, and are not better explained by autism spectrum disorder, intellectual disability (intellectual developmental disorder), global developmental delay, or another mental disorder.

Diagnostic Features

Social (pragmatic) communication disorder is characterized by a primary difficulty with pragmatics, or the social use of language and communication, as manifested by deficits in understanding and following social rules of verbal and nonverbal communication in naturalistic contexts, changing language according to the needs of the listener or situation, and following rules for conversations and storytelling. The deficits in social communication result in functional limitations in effective communication, social participation, development of social relationships, academic achievement, or occupational performance. The deficits are not better explained by low abilities in the domains of structural language or cognitive ability.

Associated Features Supporting Diagnosis

The most common associated feature of social (pragmatic) communication disorder is language impairment, which is characterized by a history of delay in reaching language milestones, and historical, if not current, structural language problems (see "Language Disorder" earlier in this chapter). Individuals with social communication deficits may avoid social interactions. Attention-deficit/hyperactivity disorder (ADHD), behavioral problems, and specific learning disorders are also more common among affected individuals.

Development and Course

Because social (pragmatic) communication depends on adequate developmental progress in speech and language, diagnosis of social (pragmatic) communication disorder is rare among children younger than 4 years. By age 4 or 5 years, most children should possess adequate speech and language abilities to permit identification of specific deficits in social communication. Milder forms of the disorder may not become apparent until early adolescence, when language and social interactions become more complex.

The outcome of social (pragmatic) communication disorder is variable, with some children improving substantially over time and others continuing to have difficulties persisting into adulthood. Even among those who have significant improvements, the early deficits in pragmatics may cause lasting impairments in social relationships and behavior and also in acquisition of other related skills, such as written expression.

Risk and Prognostic Factors

Genetic and physiological. A family history of autism spectrum disorder, communication disorders, or specific learning disorder appears to increase the risk for social (pragmatic) communication disorder.

Differential Diagnosis

Autism spectrum disorder. Autism spectrum disorder is the primary diagnostic consideration for individuals presenting with social communication deficits. The two disorders can be differentiated by the presence in autism spectrum disorder of restricted/repetitive patterns of behavior, interests, or activities and their absence in social (pragmatic) communication disorder. Individuals with autism spectrum disorder may only display the restricted/repetitive patterns of behavior, interests, and activities during the early developmental period, so a comprehensive history should be obtained. Current absence of symptoms would not preclude a diagnosis of autism spectrum disorder, if the restricted interests and repetitive behaviors were present in the past. A diagnosis of social (pragmatic) communication disorder should be considered only if the developmental history fails to reveal any evidence of restricted/repetitive patterns of behavior, interests, or activities.

Attention-deficit/hyperactivity disorder. Primary deficits of ADHD may cause impairments in social communication and functional limitations of effective communication, social participation, or academic achievement.

Social anxiety disorder (social phobia). The symptoms of social communication disorder overlap with those of social anxiety disorder. The differentiating feature is the timing of the onset of symptoms. In social (pragmatic) communication disorder, the individual has never had effective social communication; in social anxiety disorder, the social communication skills developed appropriately but are not utilized because of anxiety, fear, or distress about social interactions.

Intellectual disability (intellectual developmental disorder) and global developmental delay. Social communication skills may be deficient among individuals with global developmental delay or intellectual disability, but a separate diagnosis is not given unless the social communication deficits are clearly in excess of the intellectual limitations.

Unspecified Communication Disorder

307.9 (F80.9)

This category applies to presentations in which symptoms characteristic of communication disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for communication disorder or for any of the disorders in the neurodevelopmental disorders diagnostic class. The unspecified communication disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for communication disorder or for a specific neurodevelopmental disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Autism Spectrum Disorder

Autism Spectrum Disorder

Diagnostic Criteria **299.00 (F84.0)**

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (seeTable 2).

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:

Severity is based on social communication impairments and restricted, repetitive patterns of behavior (see Table 2).

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:

With or without accompanying intellectual impairment

With or without accompanying language impairment

Associated with a known medical or genetic condition or environmental factor (**Coding note:** Use additional code to identify the associated medical or genetic condition.)

Associated with another neurodevelopmental, mental, or behavioral disorder (**Coding note:** Use additional code[s] to identify the associated neurodevelopmental, mental, or behavioral disorder[s].)

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119–120, for definition) (**Coding note:** Use additional code 293.89 [F06.1] catatonia associated with autism spectrum disorder to indicate the presence of the comorbid catatonia.)

Recording Procedures

For autism spectrum disorder that is associated with a known medical or genetic condition or environmental factor, or with another neurodevelopmental, mental, or behavioral disorder, record autism spectrum disorder associated with (name of condition, disorder, or factor) (e.g., autism spectrum disorder associated with Rett syndrome). Severity should be recorded as level of support needed for each of the two psychopathological domains in Table 2 (e.g., "requiring very substantial support for deficits in social communication and requiring substantial support for restricted, repetitive behaviors"). Specification of "with accompanying intellectual impairment" or "without accompanying intellectual impairment" should be recorded next. Language impairment specification should be recorded thereafter. If there is accompanying language impairment, the current level of verbal functioning should be recorded (e.g., "with accompanying language impairment—no intelligible speech" or "with accompanying language impairment—phrase speech"). If catatonia is present, record separately "catatonia associated with autism spectrum disorder."

Specifiers

The severity specifiers (see Table 2) may be used to describe succinctly the current symptomatology (which might fall below level 1), with the recognition that severity may vary by context and fluctuate over time. Severity of social communication difficulties and restricted, repetitive behaviors should be separately rated. The descriptive severity categories should not be used to determine eligibility for and provision of services; these can only be developed at an individual level and through discussion of personal priorities and targets.

Regarding the specifier "with or without accompanying intellectual impairment," understanding the (often uneven) intellectual profile of a child or adult with autism spectrum disorder is necessary for interpreting diagnostic features. Separate estimates of verbal and nonverbal skill are necessary (e.g., using untimed nonverbal tests to assess potential strengths in individuals with limited language).

TABLE 2 Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and who has markedly odd nonverbal communication.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but whose to-and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

To use the specifier "with or without accompanying language impairment," the current level of verbal functioning should be assessed and described. Examples of the specific descriptions for "with accompanying language impairment" might include no intelligible speech (nonverbal), single words only, or phrase speech. Language level in individuals "without accompanying language impairment" might be further described by speaks in full sentences or has fluent speech. Since receptive language may lag behind expressive language development in autism spectrum disorder, receptive and expressive language skills should be considered separately.

The specifier "associated with a known medical or genetic condition or environmental factor" should be used when the individual has a known genetic disorder (e.g., Rett syndrome, Fragile X syndrome, Down syndrome), a medical disorder (e.g. epilepsy), or a history of environmental exposure (e.g., valproate, fetal alcohol syndrome, very low birth weight).

Additional neurodevelopmental, mental or behavioral conditions should also be noted (e.g., attention-deficit/hyperactivity disorder; developmental coordination disorder; disruptive behavior, impulse-control, or conduct disorders; anxiety, depressive, or bipolar disorders; tics or Tourette's disorder; self-injury; feeding, elimination, or sleep disorders).

Diagnostic Features

The essential features of autism spectrum disorder are persistent impairment in reciprocal social communication and social interaction (Criterion A), and restricted, repetitive patterns of behavior, interests, or activities (Criterion B). These symptoms are present from early childhood and limit or impair everyday functioning (Criteria C and D). The stage at which functional impairment becomes obvious will vary according to characteristics of the individual and his or her environment. Core diagnostic features are evident in the developmental period, but intervention, compensation, and current supports may mask difficulties in at least some contexts. Manifestations of the disorder also vary greatly depending on the severity of the autistic condition, developmental level, and chronological age; hence, the term *spectrum.* Autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder.

The impairments in communication and social interaction specified in Criterion A are pervasive and sustained. Diagnoses are most valid and reliable when based on multiple sources of information, including clinician's observations, caregiver history, and, when possible, self-report. Verbal and nonverbal deficits in social communication have varying manifestations, depending on the individual's age, intellectual level, and language ability, as well as other factors such as treatment history and current support. Many individuals have language deficits, ranging from complete lack of speech through language delays, poor comprehension of speech, echoed speech, or stilted and overly literal language. Even when formal language skills (e.g., vocabulary, grammar) are intact, the use of language for reciprocal social communication is impaired in autism spectrum disorder.

Deficits in social-emotional reciprocity (i.e., the ability to engage with others and share thoughts and feelings) are clearly evident in young children with the disorder, who may show little or no initiation of social interaction and no sharing of emotions, along with reduced or absent imitation of others' behavior. What language exists is often one-sided, lacking in social reciprocity, and used to request or label rather than to comment, share feelings, or converse. In adults without intellectual disabilities or language delays, deficits in social-emotional reciprocity may be most apparent in difficulties processing and responding to complex social cues (e.g., when and how to join a conversation, what not to say). Adults who have developed compensation strategies for some social challenges still struggle in novel or unsupported situations and suffer from the effort and anxiety of consciously calculating what is socially intuitive for most individuals.

Deficits in nonverbal communicative behaviors used for social interaction are manifested by absent, reduced, or atypical use of eye contact (relative to cultural norms), gestures, facial expressions, body orientation, or speech intonation. An early feature of autism spectrum disorder is impaired joint attention as manifested by a lack of pointing, showing, or bringing objects to share interest with others, or failure to follow someone's pointing or eye gaze. Individuals may learn a few functional gestures, but their repertoire is smaller than that of others, and they often fail to use expressive gestures spontaneously in communication. Among adults with fluent language, the difficulty in coordinating nonverbal communication with speech may give the impression of odd, wooden, or exaggerated "body language" during interactions. Impairment may be relatively subtle within individual modes (e.g., someone may have relatively good eye contact when speaking) but noticeable in poor integration of eye contact, gesture, body posture, prosody, and facial expression for social communication.

Deficits in developing, maintaining, and understanding relationships should be judged against norms for age, gender, and culture. There may be absent, reduced, or atypical social interest, manifested by rejection of others, passivity, or inappropriate approaches that seem aggressive or disruptive. These difficulties are particularly evident in young children, in whom there is often a lack of shared social play and imagination (e.g., age-appropriate flexible pretend play) and, later, insistence on playing by very fixed rules. Older individuals may struggle to understand what behavior is considered appropriate in one situation but not another (e.g., casual behavior during a job interview), or the different ways that language may be used to communicate (e.g., irony, white lies). There may be an apparent preference for solitary activities or for interacting with much younger or older people. Frequently, there is a desire to establish friendships without a complete or realistic idea of what friendship entails (e.g., one-sided friendships or friendships based solely on shared special interests). Relationships with siblings, co-workers, and caregivers are also important to consider (in terms of reciprocity).

Autism spectrum disorder is also defined by restricted, repetitive patterns of behavior, interests, or activities (as specified in Criterion B), which show a range of manifestations according to age and ability, intervention, and current supports. Stereotyped or repetitive behaviors include simple motor stereotypies (e.g., hand flapping, finger flicking), repetitive use of objects (e.g., spinning coins, lining up toys), and repetitive speech (e.g., echolalia, the delayed or immediate parroting of heard words; use of "you" when referring to self; stereotyped use of words, phrases, or prosodic patterns). Excessive adherence to routines and restricted patterns of behavior may be manifest in resistance to change (e.g., distress at apparently small changes, such as in packaging of a favorite food; insistence on adherence to rules; rigidity of thinking) or ritualized patterns of verbal or nonverbal behavior (e.g., repetitive questioning, pacing a perimeter). Highly restricted, fixated interests in autism spectrum disorder tend to be abnormal in intensity or focus (e.g., a toddler strongly attached to a pan; a child preoccupied with vacuum cleaners; an adult spending hours writing out timetables). Some fascinations and routines may relate to apparent hyper- or hyporeactivity to sensory input, manifested through extreme responses to specific sounds or textures, excessive smelling or touching of objects, fascination with lights or spinning objects, and sometimes apparent indifference to pain, heat, or cold. Extreme reaction to or rituals involving taste, smell, texture, or appearance of food or excessive food restrictions are common and may be a presenting feature of autism spectrum disorder.

Many adults with autism spectrum disorder without intellectual or language disabilities learn to suppress repetitive behavior in public. Special interests may be a source of pleasure and motivation and provide avenues for education and employment later in life. Diagnostic criteria may be met when restricted, repetitive patterns of behavior, interests, or activities were clearly present during childhood or at some time in the past, even if symptoms are no longer present.

Criterion D requires that the features must cause clinically significant impairment in social, occupational, or other important areas of current functioning. Criterion E specifies that the social communication deficits, although sometimes accompanied by intellectual disability (intellectual developmental disorder), are not in line with the individual's developmental level; impairments exceed difficulties expected on the basis of developmental level.

Standardized behavioral diagnostic instruments with good psychometric properties, including caregiver interviews, questionnaires and clinician observation measures, are available and can improve reliability of diagnosis over time and across clinicians.

Associated Features Supporting Diagnosis

Many individuals with autism spectrum disorder also have intellectual impairment and/or language impairment (e.g., slow to talk, language comprehension behind production). Even those with average or high intelligence have an uneven profile of abilities. The gap between intellectual and adaptive functional skills is often large. Motor deficits are often present, including odd gait, clumsiness, and other abnormal motor signs (e.g., walking on tiptoes). Self-injury (e.g., head banging, biting the wrist) may occur, and disruptive/challenging behaviors are more common in children and adolescents with autism spectrum disorder than other disorders, including intellectual disability. Adolescents and adults with autism spectrum disorder are prone to anxiety and depression. Some individuals develop catatonic-like motor behavior (slowing and "freezing" mid-action), but these are typically not of the magnitude of a catatonic episode. However, it is possible for individuals with autism spectrum disorder to experience a marked deterioration in motor symptoms and display a full catatonic episode with symptoms such as mutism, posturing, grimacing and waxy flexibility. The risk period for comorbid catatonia appears to be greatest in the adolescent years.

Prevalence

In recent years, reported frequencies for autism spectrum disorder across U.S. and non-U.S. countries have approached 1% of the population, with similar estimates in child and adult samples. It remains unclear whether higher rates reflect an expansion of the diagnostic criteria of DSM-IV to include subthreshold cases, increased awareness, differences in study methodology, or a true increase in the frequency of autism spectrum disorder.

Development and Course

The age and pattern of onset also should be noted for autism spectrum disorder. Symptoms are typically recognized during the second year of life (12–24 months of age) but may be seen earlier than 12 months if developmental delays are severe, or noted later than 24 months if symptoms are more subtle. The pattern of onset description might include information about early developmental delays or any losses of social or language skills. In cases where skills have been lost, parents or caregivers may give a history of a gradual or relatively rapid deterioration in social behaviors or language skills. Typically, this would occur between 12 and 24 months of age and is distinguished from the rare instances of developmental regression occurring after at least 2 years of normal development (previously described as childhood disintegrative disorder).

The behavioral features of autism spectrum disorder first become evident in early childhood, with some cases presenting a lack of interest in social interaction in the first year of life. Some children with autism spectrum disorder experience developmental plateaus or regression, with a gradual or relatively rapid deterioration in social behaviors or use of language, often during the first 2 years of life. Such losses are rare in other disorders and may be a useful "red flag" for autism spectrum disorder. Much more unusual and warranting more extensive medical investigation are losses of skills beyond social communication (e.g., loss of self-care, toileting, motor skills) or those occurring after the