

ity. However, if the motor difficulties are in excess of what could be accounted for by the intellectual disability, and criteria for developmental coordination disorder are met, developmental coordination disorder can be diagnosed as well.

Attention-deficit/hyperactivity disorder. Individuals with ADHD may fall, bump into objects, or knock things over. Careful observation across different contexts is required to ascertain if lack of motor competence is attributable to distractibility and impulsiveness rather than to developmental coordination disorder. If criteria for both ADHD and developmental coordination disorder are met, both diagnoses can be given.

Autism spectrum disorder. Individuals with autism spectrum disorder may be uninterested in participating in tasks requiring complex coordination skills, such as ball sports, which will affect test performance and function but not reflect core motor competence. Co-occurrence of developmental coordination disorder and autism spectrum disorder is common. If criteria for both disorders are met, both diagnoses can be given.

Joint hypermobility syndrome. Individuals with syndromes causing hyperextensible joints (found on physical examination; often with a complaint of pain) may present with symptoms similar to those of developmental coordination disorder.

Comorbidity

Disorders that commonly co-occur with developmental coordination disorder include speech and language disorder; specific learning disorder (especially reading and writing); problems of inattention, including ADHD (the most frequent coexisting condition, with about 50% co-occurrence); autism spectrum disorder; disruptive and emotional behavior problems; and joint hypermobility syndrome. Different clusters of co-occurrence may be present (e.g., a cluster with severe reading disorders, fine motor problems, and handwriting problems; another cluster with impaired movement control and motor planning). Presence of other disorders does not exclude developmental coordination disorder but may make testing more difficult and may independently interfere with the execution of activities of daily living, thus requiring examiner judgment in ascribing impairment to motor skills.

Stereotypic Movement Disorder

Diagnostic Criteria	307.3 (F98.4)
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- A. Repetitive, seemingly driven, and apparently purposeless motor behavior (e.g., hand shaking or waving, body rocking, head banging, self-biting, hitting own body).
- B. The repetitive motor behavior interferes with social, academic, or other activities and may result in self-injury.
- C. Onset is in the early developmental period.
- D. The repetitive motor behavior is not attributable to the physiological effects of a substance or neurological condition and is not better explained by another neurodevelopmental or mental disorder (e.g., trichotillomania [hair-pulling disorder], obsessive-compulsive disorder).

Specify if:

With self-injurious behavior (or behavior that would result in an injury if preventive measures were not used)

Without self-injurious behavior

Specify if:

Associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor (e.g., Lesch-Nyhan syndrome, intellectual disability [intellectual developmental disorder], intrauterine alcohol exposure)

Coding note: Use additional code to identify the associated medical or genetic condition, or neurodevelopmental disorder.

Specify current severity:

Mild: Symptoms are easily suppressed by sensory stimulus or distraction.

Moderate: Symptoms require explicit protective measures and behavioral modification.

Severe: Continuous monitoring and protective measures are required to prevent serious injury.

Recording Procedures

For stereotypic movement disorder that is associated with a known medical or genetic condition, neurodevelopmental disorder, or environmental factor, record stereotypic movement disorder associated with (name of condition, disorder, or factor) (e.g., stereotypic movement disorder associated with Lesch-Nyhan syndrome).

Specifiers

The severity of non-self-injurious stereotypic movements ranges from mild presentations that are easily suppressed by a sensory stimulus or distraction to continuous movements that markedly interfere with all activities of daily living. Self-injurious behaviors range in severity along various dimensions, including the frequency, impact on adaptive functioning, and severity of bodily injury (from mild bruising or erythema from hitting hand against body, to lacerations or amputation of digits, to retinal detachment from head banging).

Diagnostic Features

The essential feature of stereotypic movement disorder is repetitive, seemingly driven, and apparently purposeless motor behavior (Criterion A). These behaviors are often rhythmical movements of the head, hands, or body without obvious adaptive function. The movements may or may not respond to efforts to stop them. Among typically developing children, the repetitive movements may be stopped when attention is directed to them or when the child is distracted from performing them. Among children with neurodevelopmental disorders, the behaviors are typically less responsive to such efforts. In other cases, the individual demonstrates self-restraining behaviors (e.g., sitting on hands, wrapping arms in clothing, finding a protective device).

The repertoire of behaviors is variable; each individual presents with his or her own individually patterned, “signature” behavior. Examples of non-self-injurious stereotypic movements include, but are not limited to, body rocking, bilateral flapping or rotating hand movements, flicking or fluttering fingers in front of the face, arm waving or flapping, and head nodding. Stereotyped self-injurious behaviors include, but are not limited to, repetitive head banging, face slapping, eye poking, and biting of hands, lips, or other body parts. Eye poking is particularly concerning; it occurs more frequently among children with visual impairment. Multiple movements may be combined (e.g., cocking the head, rocking the torso, waving a small string repetitively in front of the face).

Stereotypic movements may occur many times during a day, lasting a few seconds to several minutes or longer. Frequency can vary from many occurrences in a single day to several weeks elapsing between episodes. The behaviors vary in context, occurring when the individual is engrossed in other activities, when excited, stressed, fatigued, or bored. Criterion A requires that the movements be “apparently” purposeless. However, some functions may be served by the movements. For example, stereotypic movements might reduce anxiety in response to external stressors.

Criterion B states that the stereotypic movements interfere with social, academic, or other activities and, in some children, may result in self-injury (or would if protective measures were not used). If self-injury is present, it should be coded using the specifier. Onset

of stereotypic movements is in the early developmental period (Criterion C). Criterion D states that the repetitive, stereotyped behavior in stereotypic movement disorder is not attributable to the physiological effects of a substance or neurological condition and is not better explained by another neurodevelopmental or mental disorder. The presence of stereotypic movements may indicate an undetected neurodevelopmental problem, especially in children ages 1–3 years.

Prevalence

Simple stereotypic movements (e.g., rocking) are common in young typically developing children. Complex stereotypic movements are much less common (occurring in approximately 3%–4%). Between 4% and 16% of individuals with intellectual disability (intellectual developmental disorder) engage in stereotypy and self-injury. The risk is greater in individuals with severe intellectual disability. Among individuals with intellectual disability living in residential facilities, 10%–15% may have stereotypic movement disorder with self-injury.

Development and Course

Stereotypic movements typically begin within the first 3 years of life. Simple stereotypic movements are common in infancy and may be involved in acquisition of motor mastery. In children who develop complex motor stereotypies, approximately 80% exhibit symptoms before 24 months of age, 12% between 24 and 35 months, and 8% at 36 months or older. In most typically developing children, these movements resolve over time or can be suppressed. Onset of complex motor stereotypies may be in infancy or later in the developmental period. Among individuals with intellectual disability, the stereotyped, self-injurious behaviors may persist for years, even though the typography or pattern of self-injury may change.

Risk and Prognostic Factors

Environmental. Social isolation is a risk factor for self-stimulation that may progress to stereotypic movements with repetitive self-injury. Environmental stress may also trigger stereotypic behavior. Fear may alter physiological state, resulting in increased frequency of stereotypic behaviors.

Genetic and physiological. Lower cognitive functioning is linked to greater risk for stereotypic behaviors and poorer response to interventions. Stereotypic movements are more frequent among individuals with moderate-to-severe/profound intellectual disability, who by virtue of a particular syndrome (e.g., Rett syndrome) or environmental factor (e.g., an environment with relatively insufficient stimulation) seem to be at higher risk for stereotypies. Repetitive self-injurious behavior may be a behavioral phenotype in neurogenetic syndromes. For example, in Lesch-Nyhan syndrome, there are both stereotypic dystonic movements and self-mutilation of fingers, lip biting, and other forms of self-injury unless the individual is restrained, and in Rett syndrome and Cornelia de Lange syndrome, self-injury may result from the hand-to-mouth stereotypies. Stereotypic behaviors may result from a painful medical condition (e.g., middle ear infection, dental problems, gastroesophageal reflux).

Culture-Related Diagnostic Issues

Stereotypic movement disorder, with or without self-injury, occurs in all races and cultures. Cultural attitudes toward unusual behaviors may result in delayed diagnosis. Overall cultural tolerance and attitudes toward stereotypic movement vary and must be considered.

Differential Diagnosis

Normal development. Simple stereotypic movements are common in infancy and early childhood. Rocking may occur in the transition from sleep to awake, a behavior that usu-

ally resolves with age. Complex stereotypies are less common in typically developing children and can usually be suppressed by distraction or sensory stimulation. The individual's daily routine is rarely affected, and the movements generally do not cause the child distress. The diagnosis would not be appropriate in these circumstances.

Autism spectrum disorder. Stereotypic movements may be a presenting symptom of autism spectrum disorder and should be considered when repetitive movements and behaviors are being evaluated. Deficits of social communication and reciprocity manifesting in autism spectrum disorder are generally absent in stereotypic movement disorder, and thus social interaction, social communication, and rigid repetitive behaviors and interests are distinguishing features. When autism spectrum disorder is present, stereotypic movement disorder is diagnosed only when there is self-injury or when the stereotypic behaviors are sufficiently severe to become a focus of treatment.

Tic disorders. Typically, stereotypies have an earlier age at onset (before 3 years) than do tics, which have a mean age at onset of 5–7 years. They are consistent and fixed in their pattern or topography compared with tics, which are variable in their presentation. Stereotypies may involve arms, hands, or the entire body, while tics commonly involve eyes, face, head, and shoulders. Stereotypies are more fixed, rhythmic, and prolonged in duration than tics, which, generally, are brief, rapid, random, and fluctuating. Tics and stereotypic movements are both reduced by distraction.

Obsessive-compulsive and related disorders. Stereotypic movement disorder is distinguished from obsessive-compulsive disorder (OCD) by the absence of obsessions, as well as by the nature of the repetitive behaviors. In OCD the individual feels driven to perform repetitive behaviors in response to an obsession or according to rules that must be applied rigidly, whereas in stereotypic movement disorder the behaviors are seemingly driven but apparently purposeless. Trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder are characterized by body-focused repetitive behaviors (i.e., hair pulling and skin picking) that may be seemingly driven but that are not apparently purposeless, and that may not be patterned or rhythmical. Furthermore, onset in trichotillomania and excoriation disorder is not typically in the early developmental period, but rather around puberty or later.

Other neurological and medical conditions. The diagnosis of stereotypic movements requires the exclusion of habits, mannerisms, paroxysmal dyskinesias, and benign hereditary chorea. A neurological history and examination are required to assess features suggestive of other disorders, such as myoclonus, dystonia, tics, and chorea. Involuntary movements associated with a neurological condition may be distinguished by their signs and symptoms. For example, repetitive, stereotypic movements in tardive dyskinesia can be distinguished by a history of chronic neuroleptic use and characteristic oral or facial dyskinesia or irregular trunk or limb movements. These types of movements do not result in self-injury. A diagnosis of stereotypic movement disorder is not appropriate for repetitive skin picking or scratching associated with amphetamine intoxication or abuse (e.g., patients are diagnosed with substance/medication-induced obsessive-compulsive and related disorder) and repetitive choreoathetoid movements associated with other neurological disorders.

Comorbidity

Stereotypic movement disorder may occur as a primary diagnosis or secondary to another disorder. For example, stereotypies are a common manifestation of a variety of neurogenetic disorders, such as Lesch-Nyhan syndrome, Rett syndrome, fragile X syndrome, Cornelia de Lange syndrome, and Smith-Magenis syndrome. When stereotypic movement disorder co-occurs with another medical condition, both should be coded.

Tic Disorders

Diagnostic Criteria

Note: A tic is a sudden, rapid, recurrent, nonrhythmic motor movement or vocalization.

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

- A. Both multiple motor and one or more vocal tics have been present at some time during the illness, although not necessarily concurrently.
- B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- C. Onset is before age 18 years.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, postviral encephalitis).

Persistent (Chronic) Motor or Vocal Tic Disorder **307.22 (F95.1)**

- A. Single or multiple motor or vocal tics have been present during the illness, but not both motor and vocal.
- B. The tics may wax and wane in frequency but have persisted for more than 1 year since first tic onset.
- C. Onset is before age 18 years.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, postviral encephalitis).
- E. Criteria have never been met for Tourette's disorder.

Specify if:

- With motor tics only**
- With vocal tics only**

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

- A. Single or multiple motor and/or vocal tics.
- B. The tics have been present for less than 1 year since first tic onset.
- C. Onset is before age 18 years.
- D. The disturbance is not attributable to the physiological effects of a substance (e.g., cocaine) or another medical condition (e.g., Huntington's disease, postviral encephalitis).
- E. Criteria have never been met for Tourette's disorder or persistent (chronic) motor or vocal tic disorder.

Specifiers

The "motor tics only" or "vocal tics only" specifier is only required for persistent (chronic) motor or vocal tic disorder.

Diagnostic Features

Tic disorders comprise four diagnostic categories: Tourette's disorder, persistent (chronic) motor or vocal tic disorder, provisional tic disorder, and the other specified and unspecified tic disorders. Diagnosis for any tic disorder is based on the presence of motor and/or vocal tics (Criterion A), duration of tic symptoms (Criterion B), age at onset (Criterion C), and absence of any known cause such as another medical condition or substance use (Criterion D). The tic disorders are hierarchical in order (i.e., Tourette's disorder, followed by persistent [chronic] motor or vocal tic disorder, followed by provisional tic disorder, followed by the

other specified and unspecified tic disorders), such that once a tic disorder at one level of the hierarchy is diagnosed, a lower hierarchy diagnosis cannot be made (Criterion E).

Tics are sudden, rapid, recurrent, nonrhythmic motor movements or vocalizations. An individual may have various tic symptoms over time, but at any point in time, the tic repertoire recurs in a characteristic fashion. Although tics can include almost any muscle group or vocalization, certain tic symptoms, such as eye blinking or throat clearing, are common across patient populations. Tics are generally experienced as involuntary but can be voluntarily suppressed for varying lengths of time.

Tics can be either simple or complex. *Simple motor tics* are of short duration (i.e., milliseconds) and can include eye blinking, shoulder shrugging, and extension of the extremities. Simple vocal tics include throat clearing, sniffing, and grunting often caused by contraction of the diaphragm or muscles of the oropharynx. *Complex motor tics* are of longer duration (i.e., seconds) and often include a combination of simple tics such as simultaneous head turning and shoulder shrugging. Complex tics can appear purposeful, such as a tic-like sexual or obscene gesture (*copropraxia*) or a tic-like imitation of someone else's movements (*echopraxia*). Similarly, complex vocal tics include repeating one's own sounds or words (*palilalia*), repeating the last-heard word or phrase (*echolalia*), or uttering socially unacceptable words, including obscenities, or ethnic, racial, or religious slurs (*coprolalia*). Importantly, coprolalia is an abrupt, sharp bark or grunt utterance and lacks the prosody of similar inappropriate speech observed in human interactions.

The presence of motor and/or vocal tics varies across the four tic disorders (Criterion A). For Tourette's disorder, both motor and vocal tics must be present, whereas for persistent (chronic) motor or vocal tic disorder, only motor or only vocal tics are present. For provisional tic disorder, motor and/or vocal tics may be present. For other specified or unspecified tic disorders, the movement disorder symptoms are best characterized as tics but are atypical in presentation or age at onset, or have a known etiology.

The 1-year minimum duration criterion (Criterion B) assures that individuals diagnosed with either Tourette's disorder or persistent (chronic) motor or vocal tic disorder have had persistent symptoms. Tics wax and wane in severity, and some individuals may have tic-free periods of weeks to months; however, an individual who has had tic symptoms of greater than 1 year's duration since first tic onset would be considered to have persistent symptoms regardless of duration of tic-free periods. For an individual with motor and/or vocal tics of less than 1 year since first tic onset, a provisional tic disorder diagnosis can be considered. There is no duration specification for other specified and unspecified tic disorders. The onset of tics must occur prior to age 18 years (Criterion C). Tic disorders typically begin in the prepubertal period, with an average age at onset between 4 and 6 years, and with the incidence of new-onset tic disorders decreasing in the teen years. New onset of tic symptoms in adulthood is exceedingly rare and is often associated with exposures to drugs (e.g., excessive cocaine use) or is a result of a central nervous system insult (e.g., postviral encephalitis). Although tic onset is uncommon in teenagers and adults, it is not uncommon for adolescents and adults to present for an initial diagnostic assessment and, when carefully evaluated, provide a history of milder symptoms dating back to childhood. New-onset abnormal movements suggestive of tics outside of the usual age range should result in evaluation for other movement disorders or for specific etiologies.

Tic symptoms cannot be attributable to the physiological effects of a substance or another medical condition (Criterion D). When there is strong evidence from the history, physical examination, and/or laboratory results to suggest a plausible, proximal, and probable cause for a tic disorder, a diagnosis of other specified tic disorder should be used.

Having previously met diagnostic criteria for Tourette's disorder negates a possible diagnosis of persistent (chronic) motor or vocal tic disorder (Criterion E). Similarly, a previous diagnosis of persistent (chronic) motor or vocal tic disorder negates a diagnosis of provisional tic disorder or other specified or unspecified tic disorder (Criterion E).

Prevalence

Tics are common in childhood but transient in most cases. The estimated prevalence of Tourette's disorder ranges from 3 to 8 per 1,000 in school-age children. Males are more commonly affected than females, with the ratio varying from 2:1 to 4:1. A national survey in the United States estimated 3 per 1,000 for the prevalence of clinically identified cases. The frequency of identified cases was lower among African Americans and Hispanic Americans, which may be related to differences in access to care.

Development and Course

Onset of tics is typically between ages 4 and 6 years. Peak severity occurs between ages 10 and 12 years, with a decline in severity during adolescence. Many adults with tic disorders experience diminished symptoms. A small percentage of individuals will have persistently severe or worsening symptoms in adulthood.

Tic symptoms manifest similarly in all age groups and across the lifespan. Tics wax and wane in severity and change in affected muscle groups and vocalizations over time. As children get older, they begin to report their tics being associated with a premonitory urge—a somatic sensation that precedes the tic—and a feeling of tension reduction following the expression of the tic. Tics associated with a premonitory urge may be experienced as not completely “involuntary” in that the urge and the tic can be resisted. An individual may also feel the need to perform a tic in a specific way or repeat it until he or she achieves the feeling that the tic has been done “just right.”

The vulnerability toward developing co-occurring conditions changes as individuals pass through the age of risk for various co-occurring conditions. For example, prepubertal children with tic disorders are more likely to experience attention-deficit/hyperactivity disorder (ADHD), obsessive-compulsive disorder (OCD), and separation anxiety disorder than are teenagers and adults, who are more likely to experience the new onset of major depressive disorder, substance use disorder, or bipolar disorder.

Risk and Prognostic Factors

Temperamental. Tics are worsened by anxiety, excitement, and exhaustion and are better during calm, focused activities. Individuals may have fewer tics when engaged in schoolwork or tasks at work than when relaxing at home after school or in the evening. Stressful/exciting events (e.g., taking a test, participating in exciting activities) often make tics worse.

Environmental. Observing a gesture or sound in another person may result in an individual with a tic disorder making a similar gesture or sound, which may be incorrectly perceived by others as purposeful. This can be a particular problem when the individual is interacting with authority figures (e.g., teachers, supervisors, police).

Genetic and physiological. Genetic and environmental factors influence tic symptom expression and severity. Important risk alleles for Tourette's disorder and rare genetic variants in families with tic disorders have been identified. Obstetrical complications, older paternal age, lower birth weight, and maternal smoking during pregnancy are associated with worse tic severity.

Culture-Related Diagnostic Issues

Tic disorders do not appear to vary in clinical characteristics, course, or etiology by race, ethnicity, and culture. However, race, ethnicity, and culture may impact how tic disorders are perceived and managed in the family and community, as well as influencing patterns of help seeking, and choices of treatment.

Gender-Related Diagnostic Issues

Males are more commonly affected than females, but there are no gender differences in the kinds of tics, age at onset, or course. Women with persistent tic disorders may be more likely to experience anxiety and depression.

Functional Consequences of Tic Disorders

Many individuals with mild to moderate tic severity experience no distress or impairment in functioning and may even be unaware of their tics. Individuals with more severe symptoms generally have more impairment in daily living, but even individuals with moderate or even severe tic disorders may function well. The presence of a co-occurring condition, such as ADHD or OCD, can have greater impact on functioning. Less commonly, tics disrupt functioning in daily activities and result in social isolation, interpersonal conflict, peer victimization, inability to work or to go to school, and lower quality of life. The individual also may experience substantial psychological distress. Rare complications of Tourette's disorder include physical injury, such as eye injury (from hitting oneself in the face), and orthopedic and neurological injury (e.g., disc disease related to forceful head and neck movements).

Differential Diagnosis

Abnormal movements that may accompany other medical conditions and stereotypic movement disorder. *Motor stereotypies* are defined as involuntary rhythmic, repetitive, predictable movements that appear purposeful but serve no obvious adaptive function or purpose and stop with distraction. Examples include repetitive hand waving/rotating, arm flapping, and finger wiggling. Motor stereotypies can be differentiated from tics based on the former's earlier age at onset (younger than 3 years), prolonged duration (seconds to minutes), constant repetitive fixed form and location, exacerbation when engrossed in activities, lack of a premonitory urge, and cessation with distraction (e.g., name called or touched). *Chorea* represents rapid, random, continual, abrupt, irregular, unpredictable, nonstereotyped actions that are usually bilateral and affect all parts of the body (i.e., face, trunk, and limbs). The timing, direction, and distribution of movements vary from moment to moment, and movements usually worsen during attempted voluntary action. *Dystonia* is the simultaneous sustained contracture of both agonist and antagonist muscles, resulting in a distorted posture or movement of parts of the body. Dystonic postures are often triggered by attempts at voluntary movements and are not seen during sleep.

Substance-induced and paroxysmal dyskinesias. Paroxysmal dyskinesias usually occur as dystonic or choreoathetoid movements that are precipitated by voluntary movement or exertion and less commonly arise from normal background activity.

Myoclonus. Myoclonus is characterized by a sudden unidirectional movement that is often nonrhythmic. It may be worsened by movement and occur during sleep. Myoclonus is differentiated from tics by its rapidity, lack of suppressibility, and absence of a premonitory urge.

Obsessive-compulsive and related disorders. Differentiating obsessive-compulsive behaviors from tics may be difficult. Clues favoring an obsessive-compulsive behavior include a cognitive-based drive (e.g., fear of contamination) and the need to perform the action in a particular fashion a certain number of times, equally on both sides of the body, or until a "just right" feeling is achieved. Impulse-control problems and other repetitive behaviors, including persistent hair pulling, skin picking, and nail biting, appear more goal directed and complex than tics.

Comorbidity

Many medical and psychiatric conditions have been described as co-occurring with tic disorders, with ADHD and obsessive-compulsive and related disorders being particularly common. The obsessive-compulsive symptoms observed in tic disorder tend to be characterized by more aggressive symmetry and order symptoms and poorer response to pharmacotherapy with selective serotonin reuptake inhibitors. Children with ADHD may demonstrate disruptive behavior, social immaturity, and learning difficulties that may interfere with academic progress and interpersonal relationships and lead to greater impairment than that caused by a tic disorder. Individuals with tic disorders can also have other movement disorders and other mental disorders, such as depressive, bipolar, or substance use disorders.

Other Specified Tic Disorder

307.20 (F95.8)

This category applies to presentations in which symptoms characteristic of a tic 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 a tic disorder or any of the disorders in the neurodevelopmental disorders diagnostic class. The other specified tic disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for a tic disorder or any specific neurodevelopmental disorder. This is done by recording “other specified tic disorder” followed by the specific reason (e.g., “with onset after age 18 years”).

Unspecified Tic Disorder

307.20 (F95.9)

This category applies to presentations in which symptoms characteristic of a tic 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 a tic disorder or for any of the disorders in the neurodevelopmental disorders diagnostic class. The unspecified tic disorder category is used in situations in which the clinician chooses *not* to specify the reason that the criteria are not met for a tic disorder or for a specific neurodevelopmental disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis.

Other Neurodevelopmental Disorders

Other Specified Neurodevelopmental Disorder

315.8 (F88)

This category applies to presentations in which symptoms characteristic of a neurodevelopmental disorder that cause impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the neurodevelopmental disorders diagnostic class. The other specified neurodevelopmental disorder category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific neurodevelopmental disorder. This is done by recording “other specified neurodevelopmental disorder” followed by the specific reason (e.g., “neurodevelopmental disorder associated with prenatal alcohol exposure”).

An example of a presentation that can be specified using the “other specified” designation is the following:

Neurodevelopmental disorder associated with prenatal alcohol exposure: Neurodevelopmental disorder associated with prenatal alcohol exposure is characterized by a range of developmental disabilities following exposure to alcohol in utero.

Unspecified Neurodevelopmental Disorder

315.9 (F89)

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

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms.

Key Features That Define the Psychotic Disorders

Delusions

Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose). *Persecutory delusions* (i.e., belief that one is going to be harmed, harassed, and so forth by an individual, organization, or other group) are most common. *Referential delusions* (i.e., belief that certain gestures, comments, environmental cues, and so forth are directed at oneself) are also common. *Grandiose delusions* (i.e., when an individual believes that he or she has exceptional abilities, wealth, or fame) and *erotomanic delusions* (i.e., when an individual believes falsely that another person is in love with him or her) are also seen. *Nihilistic delusions* involve the conviction that a major catastrophe will occur, and *somatic delusions* focus on preoccupations regarding health and organ function.

Delusions are deemed *bizarre* if they are clearly implausible and not understandable to same-culture peers and do not derive from ordinary life experiences. An example of a bizarre delusion is the belief that an outside force has removed his or her internal organs and replaced them with someone else's organs without leaving any wounds or scars. An example of a nonbizarre delusion is the belief that one is under surveillance by the police, despite a lack of convincing evidence. Delusions that express a loss of control over mind or body are generally considered to be bizarre; these include the belief that one's thoughts have been "removed" by some outside force (*thought withdrawal*), that alien thoughts have been put into one's mind (*thought insertion*), or that one's body or actions are being acted on or manipulated by some outside force (*delusions of control*). The distinction between a delusion and a strongly held idea is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity.

Hallucinations

Hallucinations are perception-like experiences that occur without an external stimulus. They are vivid and clear, with the full force and impact of normal perceptions, and not under voluntary control. They may occur in any sensory modality, but auditory hallucinations are the most common in schizophrenia and related disorders. Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the individual's own thoughts. The hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (*hypnagogic*) or waking up