
Desk Reference
to the
Diagnostic Criteria
From

DSM-5™

(2013)



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6. **Koro:** Related to *dhat syndrome* (see "Glossary of Cultural Concepts of Distress" in the Appendix to DSM-5), an episode of sudden and intense anxiety that the penis (or the vulva and nipples in females) will recede into the body, possibly leading to death.
7. **Jikoshu-kyofu:** A variant of *taijin kyofusho* (see "Glossary of Cultural Concepts of Distress" in the Appendix to DSM-5) characterized by fear of having an offensive body odor (also termed *olfactory reference syndrome*).

Unspecified Obsessive-Compulsive and Related Disorder

300.3 (F42)

This category applies to presentations in which symptoms characteristic of an obsessive-compulsive and related 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 any of the disorders in the obsessive-compulsive and related disorders diagnostic class. The unspecified obsessive-compulsive and related 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 obsessive-compulsive and related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Trauma- and Stressor-Related Disorders

Reactive Attachment Disorder

313.89 (F94.1)

- A. A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, manifested by both of the following:
 1. The child rarely or minimally seeks comfort when distressed.
 2. The child rarely or minimally responds to comfort when distressed.
- B. A persistent social and emotional disturbance characterized by at least two of the following:
 1. Minimal social and emotional responsiveness to others.
 2. Limited positive affect.
 3. Episodes of unexplained irritability, sadness, or fearfulness that are evident even during nonthreatening interactions with adult caregivers.
- C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
 1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
 2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).
 3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the lack of adequate care in Criterion C).

- E. The criteria are not met for autism spectrum disorder.
- F. The disturbance is evident before age 5 years.
- G. The child has a developmental age of at least 9 months.

Specify if:

Persistent: The disorder has been present for more than 12 months.

Specify current severity:

Reactive attachment disorder is specified as **severe** when a child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Disinhibited Social Engagement Disorder

313.89 (F94.2)

- A. A pattern of behavior in which a child actively approaches and interacts with unfamiliar adults and exhibits at least two of the following:
 - 1. Reduced or absent reticence in approaching and interacting with unfamiliar adults.
 - 2. Overly familiar verbal or physical behavior (that is not consistent with culturally sanctioned and with age-appropriate social boundaries).
 - 3. Diminished or absent checking back with adult caregiver after venturing away, even in unfamiliar settings.
 - 4. Willingness to go off with an unfamiliar adult with minimal or no hesitation.
- B. The behaviors in Criterion A are not limited to impulsivity (as in attention-deficit/hyperactivity disorder) but include socially disinhibited behavior.
- C. The child has experienced a pattern of extremes of insufficient care as evidenced by at least one of the following:
 - 1. Social neglect or deprivation in the form of persistent lack of having basic emotional needs for comfort, stimulation, and affection met by caregiving adults.
 - 2. Repeated changes of primary caregivers that limit opportunities to form stable attachments (e.g., frequent changes in foster care).

- 3. Rearing in unusual settings that severely limit opportunities to form selective attachments (e.g., institutions with high child-to-caregiver ratios).
- D. The care in Criterion C is presumed to be responsible for the disturbed behavior in Criterion A (e.g., the disturbances in Criterion A began following the pathogenic care in Criterion C).
- E. The child has a developmental age of at least 9 months.

Specify if:

Persistent: The disorder has been present for more than 12 months.

Specify current severity:

Disinhibited social engagement disorder is specified as **severe** when the child exhibits all symptoms of the disorder, with each symptom manifesting at relatively high levels.

Posttraumatic Stress Disorder

309.81 (F43.10)

Posttraumatic Stress Disorder

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

- A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
 - 1. Directly experiencing the traumatic event(s).
 - 2. Witnessing, in person, the event(s) as it occurred to others.
 - 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
 - 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
 2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
Note: In children, there may be frightening dreams without recognizable content.
 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
Note: In children, trauma-specific reenactment may occur in play.
 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
 5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that

arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 5. Markedly diminished interest or participation in significant activities.
 6. Feelings of detachment or estrangement from others.
 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
 2. Reckless or self-destructive behavior.
 3. Hypervigilance.
 4. Exaggerated startle response.
 5. Problems with concentration.
 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Posttraumatic Stress Disorder for Children 6 Years and Younger

- A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
 1. Directly experiencing the traumatic event(s).
 2. Witnessing, in person, the event(s) as it occurred to others, especially primary caregivers.

Note: Witnessing does not include events that are witnessed only in electronic media, television, movies, or pictures.

- 3. Learning that the traumatic event(s) occurred to a parent or caregiving figure.
- B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.

2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).

Note: It may not be possible to ascertain that the frightening content is related to the traumatic event.

3. Dissociative reactions (e.g., flashbacks) in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific reenactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to reminders of the traumatic event(s).

- C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), must be present, beginning after the event(s) or worsening after the event(s):

Persistent Avoidance of Stimuli

1. Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event(s).

2. Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).

Negative Alterations in Cognitions

3. Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
 4. Markedly diminished interest or participation in significant activities, including constriction of play.
 5. Socially withdrawn behavior.
 6. Persistent reduction in expression of positive emotions.
- D. Alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
 2. Hypervigilance.
 3. Exaggerated startle response.
 4. Problems with concentration.
 5. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- E. The duration of the disturbance is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- G. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside ob-

server of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts) or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Acute Stress Disorder

308.3 (F43.0)

- A. Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

- B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation,

avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific re-enactment may occur in play.
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or one-self (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing

memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
 11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
 12. Hypervigilance.
 13. Problems with concentration.
 14. Exaggerated startle response.
- C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
- Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.

Adjustment Disorders

- A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- B. These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:
 1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.

2. Significant impairment in social, occupational, or other important areas of functioning.
- C. The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a pre-existing mental disorder.
- D. The symptoms do not represent normal bereavement.
- E. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Specify whether:

309.0 (F43.21) With depressed mood: Low mood, tearfulness, or feelings of hopelessness are predominant.

309.24 (F43.22) With anxiety: Nervousness, worry, jitteriness, or separation anxiety is predominant.

309.28 (F43.23) With mixed anxiety and depressed mood: A combination of depression and anxiety is predominant.

309.3 (F43.24) With disturbance of conduct: Disturbance of conduct is predominant.

309.4 (F43.25) With mixed disturbance of emotions and conduct: Both emotional symptoms (e.g., depression, anxiety) and a disturbance of conduct are predominant.

309.9 (F43.20) Unspecified: For maladaptive reactions that are not classifiable as one of the specific subtypes of adjustment disorder.

Other Specified Trauma- and Stressor-Related Disorder

309.89 (F43.8)

This category applies to presentations in which symptoms characteristic of a trauma- and stressor-related 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 any of the disorders in the trauma- and stressor-related disorders diagnostic class. The other specified trauma- and stressor-related 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 trauma- and stressor-related disorder. This is done by recording "other specified trauma- and stressor-related disorder" followed by the specific reason (e.g., "persistent complex bereavement disorder").

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Adjustment-like disorders with delayed onset of symptoms that occur more than 3 months after the stressor.**
2. **Adjustment-like disorders with prolonged duration of more than 6 months without prolonged duration of stressor.**
3. **Ataque de nervios:** See "Glossary of Cultural Concepts of Distress" in the Appendix to DSM-5.
4. **Other cultural syndromes:** See "Glossary of Cultural Concepts of Distress" in the Appendix to DSM-5.
5. **Persistent complex bereavement disorder:** This disorder is characterized by severe and persistent grief and mourning reactions (see the chapter "Conditions for Further Study" in Section III of DSM-5).

Unspecified Trauma- and Stressor-Related Disorder

309.9 (F43.9)

This category applies to presentations in which symptoms characteristic of a trauma- and stressor-related 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 any of the disorders in the trauma- and stressor-related disorders diagnostic class. The unspecified trauma- and stressor-related 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 trauma- and stressor-related disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

with younger persons at higher risk for winter depressive episodes.

Specify if:

In partial remission: Symptoms of the immediately previous manic, hypomanic, or depressive episode are present, but full criteria are not met, or there is a period lasting less than 2 months without any significant symptoms of a manic, hypomanic, or major depressive episode following the end of such an episode.

In full remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

Specify current severity:

Severity is based on the number of criterion symptoms, the severity of those symptoms, and the degree of functional disability.

Mild: Few, if any, symptoms in excess of those required to meet the diagnostic criteria are present, the intensity of the symptoms is distressing but manageable, and the symptoms result in minor impairment in social or occupational functioning.

Moderate: The number of symptoms, intensity of symptoms, and/or functional impairment are between those specified for "mild" and "severe."

Severe: The number of symptoms is substantially in excess of those required to make the diagnosis, the intensity of the symptoms is seriously distressing and unmanageable, and the symptoms markedly interfere with social and occupational functioning.

Depressive Disorders

Disruptive Mood Dysregulation Disorder

296.99 (F34.8)

- A. Severe recurrent temper outbursts manifested verbally (e.g., verbal rages) and/or behaviorally (e.g., physical aggression toward people or property) that are grossly out of proportion in intensity or duration to the situation or provocation.
- B. The temper outbursts are inconsistent with developmental level.
- C. The temper outbursts occur, on average, three or more times per week.
- D. The mood between temper outbursts is persistently irritable or angry most of the day, nearly every day, and is observable by others (e.g., parents, teachers, peers).
- E. Criteria A–D have been present for 12 or more months. Throughout that time, the individual has not had a period lasting 3 or more consecutive months without all of the symptoms in Criteria A–D.
- F. Criteria A and D are present in at least two of three settings (i.e., at home, at school, with peers) and are severe in at least one of these.
- G. The diagnosis should not be made for the first time before age 6 years or after age 18 years.
- H. By history or observation, the age at onset of Criteria A–E is before 10 years.
- I. There has never been a distinct period lasting more than 1 day during which the full symptom criteria, except duration, for a manic or hypomanic episode have been met.
Note: Developmentally appropriate mood elevation, such as occurs in the context of a highly positive event or its anticipation, should not be considered as a symptom of mania or hypomania.
- J. The behaviors do not occur exclusively during an episode of major depressive disorder and are not better explained by another

mental disorder (e.g., autism spectrum disorder, posttraumatic stress disorder, separation anxiety disorder, persistent depressive disorder [dysthymia]).

Note: This diagnosis cannot coexist with oppositional defiant disorder, intermittent explosive disorder, or bipolar disorder, though it can coexist with others, including major depressive disorder, attention-deficit/hyperactivity disorder, conduct disorder, and substance use disorders. Individuals whose symptoms meet criteria for both disruptive mood dysregulation disorder and oppositional defiant disorder should only be given the diagnosis of disruptive mood dysregulation disorder. If an individual has ever experienced a manic or hypomanic episode, the diagnosis of disruptive mood dysregulation disorder should not be assigned.

- K. The symptoms are not attributable to the physiological effects of a substance or to another medical or neurological condition.

Major Depressive Disorder

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

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
 6. Fatigue or loss of energy nearly every day.
 7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
 8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
 9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A–C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.¹

- D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

| Severity/course specifier | Single episode | Recurrent episode* |
|---------------------------------------|----------------|--------------------|
| Mild (p. 114) | 296.21 (F32.0) | 296.31 (F33.0) |
| Moderate (p. 114) | 296.22 (F32.1) | 296.32 (F33.1) |
| Severe (p. 114) | 296.23 (F32.2) | 296.33 (F33.2) |
| With psychotic features** (p. 111) | 296.24 (F32.3) | 296.34 (F33.3) |
| In partial remission (p. 114) | 296.25 (F32.4) | 296.35 (F33.41) |

¹In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in an MDE, it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of an MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of an MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in an MDE. In grief, self-esteem is generally preserved, whereas in an MDE, feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in an MDE, such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

| Severity/course specifier | Single episode | Recurrent episode* |
|----------------------------|----------------|--------------------|
| In full remission (p. 114) | 296.26 (F32.5) | 296.36 (F33.42) |
| Unspecified | 296.20 (F32.9) | 296.30 (F33.9) |

*For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode. The definitions of specifiers are found on the indicated pages.

**If psychotic features are present, code the "with psychotic features" specifier irrespective of episode severity.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission specifiers, followed by as many of the following specifiers without codes that apply to the current episode.

Specify:

With anxious distress (pp. 107–108)

With mixed features (pp. 108–109)

With melancholic features (pp. 109–110)

With atypical features (pp. 110–111)

With mood-congruent psychotic features (p. 111)

With mood-incongruent psychotic features (p. 111)

With catatonia (p. 111). **Coding note:** Use additional code 293.89 (F06.1).

With peripartum onset (pp. 111–112)

With seasonal pattern (recurrent episode only) (pp. 113–114)

Persistent Depressive Disorder (Dysthymia)

300.4 (F34.1)

This disorder represents a consolidation of DSM-IV-defined chronic major depressive disorder and dysthymic disorder.

- A. Depressed mood for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least 2 years.

Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

- B. Presence, while depressed, of two (or more) of the following:
1. Poor appetite or overeating.
 2. Insomnia or hypersomnia.
 3. Low energy or fatigue.
 4. Low self-esteem.
 5. Poor concentration or difficulty making decisions.
 6. Feelings of hopelessness.
- C. During the 2-year period (1 year for children or adolescents) of the disturbance, the individual has never been without the symptoms in Criteria A and B for more than 2 months at a time.
- D. Criteria for a major depressive disorder may be continuously present for 2 years.
- E. There has never been a manic episode or a hypomanic episode, and criteria have never been met for cyclothymic disorder.
- F. The disturbance is not better explained by a persistent schizoaffective disorder, schizophrenia, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.
- G. The symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: Because the criteria for a major depressive episode include four symptoms that are absent from the symptom list for persistent depressive disorder (dysthymia), a very limited number of individuals will have depressive symptoms that have persisted longer than 2 years but will not meet criteria for persistent depressive disorder. If full criteria for a major depressive episode have been met at some point during the current episode of illness, they should be given a diagnosis of major depressive disorder. Otherwise, a diagnosis of other specified depressive disorder or unspecified depressive disorder is warranted.

Specify if:

With anxious distress (pp. 107–108)

With mixed features (pp. 108–109)

With melancholic features (pp. 109–110)

With atypical features (pp. 110–111)

With mood-congruent psychotic features (p. 111)

With mood-incongruent psychotic features (p. 111)

With peripartum onset (pp. 111–112)

Specify if:

In partial remission (p. 114)

In full remission (p. 114)

Specify if:

Early onset: If onset is before age 21 years.

Late onset: If onset is at age 21 years or older.

Specify if (for most recent 2 years of persistent depressive disorder):

With pure dysthymic syndrome: Full criteria for a major depressive episode have not been met in at least the preceding 2 years.

With persistent major depressive episode: Full criteria for a major depressive episode have been met throughout the preceding 2-year period.

With intermittent major depressive episodes, with current episode: Full criteria for a major depressive episode are currently met, but there have been periods of at least 8 weeks in at least the preceding 2 years with symptoms below the threshold for a full major depressive episode.

With intermittent major depressive episodes, without current episode: Full criteria for a major depressive episode are not currently met, but there has been one or more major depressive episodes in at least the preceding 2 years.

Specify current severity:

Mild (p. 114)

Moderate (p. 114)

Severe (p. 114)

Social Anxiety Disorder (Social Phobia)

300.23 (F40.10)

- A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

- B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
- C. The social situations almost always provoke fear or anxiety.

Note: In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.

- D. The social situations are avoided or endured with intense fear or anxiety.
- E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
- J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

Performance only: If the fear is restricted to speaking or performing in public.

Panic Disorder

300.01 (F41.0)

- A. Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

- B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, "going crazy").

2. A significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).
- C. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).
- D. The disturbance is not better explained by another mental disorder (e.g., the panic attacks do not occur only in response to feared social situations, as in social anxiety disorder; in response to circumscribed phobic objects or situations, as in specific phobia; in response to obsessions, as in obsessive-compulsive disorder; in response to reminders of traumatic events, as in posttraumatic stress disorder; or in response to separation from attachment figures, as in separation anxiety disorder).

Panic Attack Specifier

Note: Symptoms are presented for the purpose of identifying a panic attack; however, panic attack is not a mental disorder and cannot be coded. Panic attacks can occur in the context of any anxiety disorder as well as other mental disorders (e.g., depressive disorders, posttraumatic stress disorder, substance use disorders) and some medical conditions (e.g., cardiac, respiratory, vestibular, gastrointestinal). When the presence of a panic attack is identified, it should be noted as a specifier (e.g., "posttraumatic stress disorder with panic attacks"). For panic disorder, the presence of panic attack is contained within the criteria for the disorder and panic attack is not used as a specifier.

An abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.

6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

Agoraphobia

300.22 (F40.00)

- A. Marked fear or anxiety about two (or more) of the following five situations:
 1. Using public transportation (e.g., automobiles, buses, trains, ships, planes).
 2. Being in open spaces (e.g., parking lots, marketplaces, bridges).
 3. Being in enclosed places (e.g., shops, theaters, cinemas).
 4. Standing in line or being in a crowd.
 5. Being outside of the home alone.
- B. The individual fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g., fear of falling in the elderly; fear of incontinence).
- C. The agoraphobic situations almost always provoke fear or anxiety.
- D. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.

- E. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
- F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- H. If another medical condition (e.g., inflammatory bowel disease, Parkinson's disease) is present, the fear, anxiety, or avoidance is clearly excessive.
- I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder—for example, the symptoms are not confined to specific phobia, situational type; do not involve only social situations (as in social anxiety disorder); and are not related exclusively to obsessions (as in obsessive-compulsive disorder), perceived defects or flaws in physical appearance (as in body dysmorphic disorder), reminders of traumatic events (as in posttraumatic stress disorder), or fear of separation (as in separation anxiety disorder).

Note: Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual's presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

Generalized Anxiety Disorder

300.02 (F41.1)

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):

Note: Only one item is required in children.

- 1. Restlessness or feeling keyed up or on edge.
- 2. Being easily fatigued.

- 3. Difficulty concentrating or mind going blank.
- 4. Irritability.
- 5. Muscle tension.
- 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder).

Substance/Medication-Induced Anxiety Disorder

- A. Panic attacks or anxiety is predominant in the clinical picture.
- B. There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):
 - 1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
 - 2. The involved substance/medication is capable of producing the symptoms in Criterion A.
- C. The disturbance is not better explained by an anxiety disorder that is not substance/medication-induced. Such evidence of an independent anxiety disorder could include the following:

tions in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for any specific disruptive, impulse-control, and conduct disorder. This is done by recording "other specified disruptive, impulse-control, and conduct disorder" followed by the specific reason (e.g., "recurrent behavioral outbursts of insufficient frequency").

Unspecified Disruptive, Impulse-Control, and Conduct Disorder

312.9 (F91.9)

This category applies to presentations in which symptoms characteristic of a disruptive, impulse-control, and conduct 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 any of the disorders in the disruptive, impulse-control, and conduct disorders diagnostic class. The unspecified disruptive, impulse-control, and conduct 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 disruptive, impulse-control, and conduct disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Substance-Related and Addictive Disorders

The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances. These 10 classes are not fully distinct. All drugs that are taken in excess have in common direct activation of the brain reward system, which is involved in the reinforcement of behaviors and the production of memories. They produce such an intense activation of the reward system that normal activities may be neglected.

In addition to the substance-related disorders, this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to the substance use disorders.

The substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. The following conditions may be classified as substance-induced: intoxication, withdrawal, and other substance/medication-induced mental disorders (psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders).

Reflecting some unique aspects of the 10 substance classes relevant to this chapter, the remainder of the chapter is organized by the class of substance. To facilitate differential diagnosis, the criteria for the substance/medication-induced mental disorders are included with disorders with which they share phenomenology (e.g., substance/medication-induced depressive disorder is in the chapter "Depressive Disorders"). The broad diagnostic categories associated with each specific group of substances are shown in the Table 1.

Substance-Related Disorders

Substance Use Disorders

Recording Procedures for Substance Use Disorders

The clinician should use the code that applies to the class of substances but record the name of the *specific substance*. For example, the clinician should record 304.10 (F13.20) moderate alprazolam use disorder (rather than moderate sedative, hypnotic, or anxiolytic use disorder) or 305.70 (F15.10) mild methamphetamine use disorder (rather than mild stimulant use disorder). For substances that do not fit into any of the classes (e.g., anabolic steroids), the appropriate code for "other substance use disorder" should be used and the specific substance indicated (e.g., 305.90 [F19.10] mild anabolic steroid use disorder). If the substance taken by the individual is unknown, the code for the class "other (or unknown)" should be used (e.g., 304.90 [F19.20] severe unknown substance use disorder). If criteria are met for more than one substance use disorder, all should be diagnosed (e.g., 304.00 [F11.20] severe heroin use disorder; 304.20 [F14.20] moderate cocaine use disorder).

The appropriate ICD-10-CM code for a substance use disorder depends on whether there is a comorbid substance-induced disorder (including intoxication and withdrawal). In the above example, the diagnostic code for moderate alprazolam use disorder, F13.20, reflects the absence of a comorbid alprazolam-induced mental disorder. Because ICD-10-CM codes for substance-induced disorders indicate both the presence (or absence) and severity of the substance use disorder, ICD-10-CM codes for substance use disorders can be used only in the absence of a substance-induced disorder. See the individual substance-specific sections for additional coding information.

Note that the word *addiction* is not applied as a diagnostic term in this classification, although it is in common usage in many countries to describe severe problems related to compulsive and habitual use of substances. The more neutral term *substance use disorder* is used to describe the wide range of the disorder, from a mild form to a severe

state of chronically relapsing, compulsive drug taking. Some clinicians will choose to use the word *addiction* to describe more extreme presentations, but the word is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation.

Substance-Induced Disorders

Recording Procedures for Intoxication and Withdrawal

The clinician should use the code that applies to the class of substances but record the name of the *specific substance*. For example, the clinician should record 292.0 (F13.239) secobarbital withdrawal (rather than sedative, hypnotic, or anxiolytic withdrawal) or 292.89 (F15.129) methamphetamine intoxication (rather than stimulant intoxication). Note that the appropriate ICD-10-CM diagnostic code for intoxication depends on whether there is a comorbid substance use disorder. In this case, the F15.129 code for methamphetamine indicates the presence of a comorbid mild methamphetamine use disorder. If there had been no comorbid methamphetamine use disorder, the diagnostic code would have been F15.929. ICD-10-CM coding rules require that all withdrawal codes imply a comorbid moderate to severe substance use disorder for that substance. In the above case, the code for secobarbital withdrawal (F13.239) indicates the comorbid presence of a moderate to severe secobarbital use disorder. See the coding note for the substance-specific intoxication and withdrawal syndromes for the actual coding options.

For substances that do not fit into any of the classes (e.g., anabolic steroids), the appropriate code for "other substance intoxication" should be used and the specific substance indicated (e.g., 292.89 [F19.929] anabolic steroid intoxication). If the substance taken by the individual is unknown, the code for the class "other (or unknown)" should be used (e.g., 292.89 [F19.929] unknown substance intoxication). If there are symptoms or problems associated with a particular substance but criteria are not met for any of the substance-specific disorders, the unspecified category can be used (e.g., 292.9 [F12.99] unspecified cannabis-related disorder).

Somatic Symptom and Related Disorders

Somatic Symptom Disorder

300.82 (F45.1)

- A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.
- B. Excessive thoughts, feelings, or behaviors related to the somatic symptoms or associated health concerns as manifested by at least one of the following:
 - 1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
 - 2. Persistently high level of anxiety about health or symptoms.
 - 3. Excessive time and energy devoted to these symptoms or health concerns.
- C. Although any one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months).

Specify if:

With predominant pain (previously pain disorder): This specifier is for individuals whose somatic symptoms predominantly involve pain.

Specify if:

Persistent: A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months).

Specify current severity:

Mild: Only one of the symptoms specified in Criterion B is fulfilled.

Moderate: Two or more of the symptoms specified in Criterion B are fulfilled.

Severe: Two or more of the symptoms specified in Criterion B are fulfilled, plus there are multiple somatic complaints (or one very severe somatic symptom).

Illness Anxiety Disorder

300.7 (F45.21)

- A. Preoccupation with having or acquiring a serious illness.
- B. Somatic symptoms are not present or, if present, are only mild in intensity. If another medical condition is present or there is a high risk for developing a medical condition (e.g., strong family history is present), the preoccupation is clearly excessive or disproportionate.
- C. There is a high level of anxiety about health, and the individual is easily alarmed about personal health status.
- D. The individual performs excessive health-related behaviors (e.g., repeatedly checks his or her body for signs of illness) or exhibits maladaptive avoidance (e.g., avoids doctor appointments and hospitals).
- E. Illness preoccupation has been present for at least 6 months, but the specific illness that is feared may change over that period of time.
- F. The illness-related preoccupation is not better explained by another mental disorder, such as somatic symptom disorder, panic disorder, generalized anxiety disorder, body dysmorphic disorder, obsessive-compulsive disorder, or delusional disorder, somatic type.

Specify whether:

Care-seeking type: Medical care, including physician visits or undergoing tests and procedures, is frequently used.

Care-avoidant type: Medical care is rarely used.

Conversion Disorder (Functional Neurological Symptom Disorder)

- A. One or more symptoms of altered voluntary motor or sensory function.
- B. Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions.
- C. The symptom or deficit is not better explained by another medical or mental disorder.
- D. The symptom or deficit causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or warrants medical evaluation.

Coding note: The ICD-9-CM code for conversion disorder is **300.11**, which is assigned regardless of the symptom type. The ICD-10-CM code depends on the symptom type (see below).

Specify symptom type:

(F44.4) With weakness or paralysis

(F44.4) With abnormal movement (e.g., tremor, dystonic movement, myoclonus, gait disorder)

(F44.4) With swallowing symptoms

(F44.4) With speech symptom (e.g., dysphonia, slurred speech)

(F44.5) With attacks or seizures

(F44.6) With anesthesia or sensory loss

(F44.6) With special sensory symptom (e.g., visual, olfactory, or hearing disturbance)

(F44.7) With mixed symptoms

Specify if:

Acute episode: Symptoms present for less than 6 months.

Persistent: Symptoms occurring for 6 months or more.

Specify if:

With psychological stressor (*specify stressor*)

Without psychological stressor

Psychological Factors Affecting Other Medical Conditions

316 (F54)

- A. A medical symptom or condition (other than a mental disorder) is present.
- B. Psychological or behavioral factors adversely affect the medical condition in one of the following ways:
 - 1. The factors have influenced the course of the medical condition as shown by a close temporal association between the psychological factors and the development or exacerbation of, or delayed recovery from, the medical condition.
 - 2. The factors interfere with the treatment of the medical condition (e.g., poor adherence).
 - 3. The factors constitute additional well-established health risks for the individual.
 - 4. The factors influence the underlying pathophysiology, precipitating or exacerbating symptoms or necessitating medical attention.
- C. The psychological and behavioral factors in Criterion B are not better explained by another mental disorder (e.g., panic disorder, major depressive disorder, posttraumatic stress disorder).

Specify current severity:

Mild: Increases medical risk (e.g., inconsistent adherence with antihypertension treatment).

Moderate: Aggravates underlying medical condition (e.g., anxiety aggravating asthma).

Severe: Results in medical hospitalization or emergency room visit.

Extreme: Results in severe, life-threatening risk (e.g., ignoring heart attack symptoms).

Factitious Disorder

300.19 (F68.10)

Factitious Disorder Imposed on Self

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, associated with identified deception.
- B. The individual presents himself or herself to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Factitious Disorder Imposed on Another (Previously Factitious Disorder by Proxy)

- A. Falsification of physical or psychological signs or symptoms, or induction of injury or disease, in another, associated with identified deception.
- B. The individual presents another individual (victim) to others as ill, impaired, or injured.
- C. The deceptive behavior is evident even in the absence of obvious external rewards.
- D. The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder.

Note: The perpetrator, not the victim, receives this diagnosis.

Specify:

Single episode

Recurrent episodes (two or more events of falsification of illness and/or induction of injury)

Recording Procedures

When an individual falsifies illness in another (e.g., children, adults, pets), the diagnosis is factitious disorder imposed on another. The perpetrator, not the victim, is given the diagnosis. The victim may be given an abuse diagnosis (e.g., 995.54 [T74.12X]; see the chapter "Other Conditions That May Be a Focus of Clinical Attention").

Other Specified Somatic Symptom and Related Disorder

300.89 (F45.8)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related 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 any of the disorders in the somatic symptom and related disorders diagnostic class.

Examples of presentations that can be specified using the "other specified" designation include the following:

1. **Brief somatic symptom disorder:** Duration of symptoms is less than 6 months.
 2. **Brief illness anxiety disorder:** Duration of symptoms is less than 6 months.
 3. **Illness anxiety disorder without excessive health-related behaviors:** Criterion D for illness anxiety disorder is not met.
 4. **Pseudocyesis:** A false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.
-

Unspecified Somatic Symptom and Related Disorder

300.82 (F45.9)

This category applies to presentations in which symptoms characteristic of a somatic symptom and related 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 any of the disorders in the somatic symptom and related disorders diagnostic class. The unspecified somatic symptom and related disorder category should not be used unless there are decidedly unusual situations where there is insufficient information to make a more specific diagnosis.
