DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS

FIFTH EDITION

DSM-5™

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

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

The Multiaxial System

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

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

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

Online Enhancements

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

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

DSM-5 Classification

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

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

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

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

Neurodevelopmental Disorders (31)

Intellectual Disabilities (33)

319 (___.__) Intellectual Disability (Intellectual Developmental Disorder) (33)
Specify current severity:
(F70) Mild
(F71) Moderate
(F72) Severe
(F73) Profound

315.8 (F88) Global Developmental Delay (41)

319 (F79) Unspecified Intellectual Disability (Intellectual Developmental Disorder) (41)

Communication Disorders (41)

315.39 (F80.9) Language Disorder (42)

315.39 (F80.0) Speech Sound Disorder (44)

315.35 (F80.81) Childhood-Onset Fluency Disorder (Stuttering) (45)
Note: Later-onset cases are diagnosed as 307.0 (F98.5) adult-onset fluency disorder.

315.39 (F80.89) Social (Pragmatic) Communication Disorder (47)

307.9 (F80.9) Unspecified Communication Disorder (49)

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

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

293.89 (F06.1) Unspecified Catatonia (121)

Note: Code first **781.99 (R29.818)** other symptoms involving nervous and musculoskeletal systems.

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

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

Bipolar and Related Disorders (123)

The following specifiers apply to Bipolar and Related Disorders where indicated:

[a]*Specify:* With anxious distress (*specify* current severity: mild, moderate, moderate-severe, severe); With mixed features; With rapid cycling; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia (use additional code 293.89 [F06.1]); With peripartum onset; With seasonal pattern

___.__ (___.__) Bipolar I Disorder[a] (123)

___.__ (___.__) Current or most recent episode manic

296.41 (F31.11) Mild

296.42 (F31.12) Moderate

296.43 (F31.13) Severe

296.44 (F31.2) With psychotic features

296.45 (F31.73) In partial remission

296.46 (F31.74) In full remission

296.40 (F31.9) Unspecified

296.40 (F31.0) Current or most recent episode hypomanic

296.45 (F31.73) In partial remission

296.46 (F31.74) In full remission

296.40 (F31.9) Unspecified

___.__ (___.__) Current or most recent episode depressed

296.51 (F31.31) Mild

296.52 (F31.32) Moderate

296.53 (F31.4) Severe

296.54 (F31.5) With psychotic features

296.55 (F31.75) In partial remission

296.56 (F31.76) In full remission

296.50 (F31.9) Unspecified

296.7 (F31.9) Current or most recent episode unspecified

296.89 (F31.81) Bipolar II Disorder[a] (132)

Specify current or most recent episode: Hypomanic, Depressed

Specify course if full criteria for a mood episode are not currently met: In partial remission, In full remission

Specify severity if full criteria for a mood episode are not currently met: Mild, Moderate, Severe

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

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

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

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

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

Depressive Disorders (155)

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

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

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

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

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

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

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

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

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

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

Anxiety Disorders (189)

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

312.23 (F94.0) Selective Mutism (195)

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

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

300.01 (F41.0) Panic Disorder (208)

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

300.22 (F40.00) Agoraphobia (217)

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

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

Obsessive-Compulsive and Related Disorders (235)

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

Trauma- and Stressor-Related Disorders (265)

Feeding and Eating Disorders (329)

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

Elimination Disorders (355)

Comorbidity

Social anxiety disorder is often comorbid with other anxiety disorders, major depressive disorder, and substance use disorders, and the onset of social anxiety disorder generally precedes that of the other disorders, except for specific phobia and separation anxiety disorder. Chronic social isolation in the course of a social anxiety disorder may result in major depressive disorder. Comorbidity with depression is high also in older adults. Substances may be used as self-medication for social fears, but the symptoms of substance intoxication or withdrawal, such as trembling, may also be a source of (further) social fear. Social anxiety disorder is frequently comorbid with bipolar disorder or body dysmorphic disorder; for example, an individual has body dysmorphic disorder concerning a preoccupation with a slight irregularity of her nose, as well as social anxiety disorder because of a severe fear of sounding unintelligent. The more generalized form of social anxiety disorder, but not social anxiety disorder, performance only, is often comorbid with avoidant personality disorder. In children, comorbidities with high-functioning autism and selective mutism are common.

Panic Disorder

Diagnostic Criteria **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).

Diagnostic Features

Panic disorder refers to recurrent unexpected panic attacks (Criterion A). 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 a list of 13 physical and cognitive symptoms occur. The term *recurrent* literally means more than one unexpected panic attack. The term *unexpected* refers to a panic attack for which there is no obvious cue or trigger at the time of occurrence—that is, the attack appears to occur from out of the blue, such as when the individual is relaxing or emerging from sleep (nocturnal panic attack). In contrast, *expected* panic attacks are attacks for which there is an obvious cue or trigger, such as a situation in which panic attacks typically occur. The determination of whether panic attacks are expected or unexpected is made by the clinician, who makes this judgment based on a combination of careful questioning as to the sequence of events preceding or leading up to the attack and the individual's own judgment of whether or not the attack seemed to occur for no apparent reason. Cultural interpretations may influence the assignment of panic attacks as expected or unexpected (see section "Culture-Related Diagnostic Issues" for this disorder). In the United States and Europe, approximately one-half of individuals with panic disorder have expected panic attacks as well as unexpected panic attacks. Thus, the presence of expected panic attacks does not rule out the diagnosis of panic disorder. For more details regarding expected versus unexpected panic attacks, see the text accompanying panic attacks (pp. 214–217).

The frequency and severity of panic attacks vary widely. In terms of frequency, there may be moderately frequent attacks (e.g., one per week) for months at a time, or short bursts of more frequent attacks (e.g., daily) separated by weeks or months without any attacks or with less frequent attacks (e.g., two per month) over many years. Persons who have infrequent panic attacks resemble persons with more frequent panic attacks in terms of panic attack symptoms, demographic characteristics, comorbidity with other disorders, family history, and biological data. In terms of severity, individuals with panic disorder may have both full-symptom (four or more symptoms) and limited-symptom (fewer than four symptoms) attacks, and the number and type of panic attack symptoms frequently differ from one panic attack to the next. However, more than one unexpected full-symptom panic attack is required for the diagnosis of panic disorder.

The worries about panic attacks or their consequences usually pertain to physical concerns, such as worry that panic attacks reflect the presence of life-threatening illnesses (e.g., cardiac disease, seizure disorder); social concerns, such as embarrassment or fear of being judged negatively by others because of visible panic symptoms; and concerns about mental functioning, such as "going crazy" or losing control (Criterion B). The maladaptive changes in behavior represent attempts to minimize or avoid panic attacks or their consequences. Examples include avoiding physical exertion, reorganizing daily life to ensure that help is available in the event of a panic attack, restricting usual daily activities, and avoiding agoraphobia-type situations, such as leaving home, using public transportation, or shopping. If agoraphobia is present, a separate diagnosis of agoraphobia is given.

with alcohol or medications. Comorbidity with other anxiety disorders and illness anxiety disorder is also common.

Panic disorder is significantly comorbid with numerous general medical symptoms and conditions, including, but not limited to, dizziness, cardiac arrhythmias, hyperthyroidism, asthma, COPD, and irritable bowel syndrome. However, the nature of the association (e.g., cause and effect) between panic disorder and these conditions remains unclear. Although mitral valve prolapse and thyroid disease are more common among individuals with panic disorder than in the general population, the differences in prevalence are not consistent.