Module 7: Differential Diagnosis, Scope of Practice, and the Addressing of Neurocognitive Disorders, Schizophrenia Spectrum and Other Psychotic Disorders and Bipolar and Related Disorders
Your Presenters

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Becky Beaton, PhD
Dr. Becky Beaton is the Founder and Director of The Anxiety & Stress Management Institute in Atlanta. She has taught numerous workshops both nationally and internationally. In 2005, she was voted Counselor Educator of the Year by the Licensed Professional Counselor's Association of Georgia.

Charlie Safford, LCSW
President, yourceus.com, Inc.
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of neurocognitive disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining neurocognitive disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing neurocognitive disorders diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for neurocognitive disorders
- Learn appropriate treatment strategies based upon diagnosis
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of schizophrenia spectrum and other psychotic disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining schizophrenia spectrum and other psychotic disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing schizophrenia spectrum and other psychotic disorders diagnoses
- Comprehend differential diagnosis from other disorders with similar presentations
- Apply common specifiers for schizophrenia spectrum and other psychotic disorders
- Learn appropriate treatment strategies based upon diagnosis
Course Objectives

Upon completion of this program trainees will:

- Learn the etiology of bipolar and related disorders based on current research
- Comprehend the complexities of diagnosis for this disorder
- Grasp appropriate assessment processes for determining bipolar and related disorders, role clarification and differentiation for master’s level clinicians, and appropriate referrals to other professionals in establishing bipolar and related disorders diagnoses
- Comprehend differential diagnosis with other disorders with similar presentations
- Apply common specifiers for bipolar and related disorders
- Learn appropriate treatment strategies based upon diagnosis
Purposes Behind Diagnosis

- Accurate diagnosis allows for **consistency and standardization** throughout all disciplines that address mental health concerns: medical, nursing, psychiatric, psychological, counseling, social work, marriage and family therapy.
- Accurate diagnosis allows for **common ground** to be established in terms of research concerning the **effectiveness of various kinds of treatment**.
- Accurate diagnosis can be used for **shaping the client's treatment plan**, aligning the treatment approaches research has determined to be most effective with the various diagnostic categories.
Boundaries around Assessment:

Who Makes the Diagnosis for Complex Disorders?
1.04 Competence

(a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
The Biopsychosocial Perspective

Source: Ross, DE
A Method for Developing a Biopsychosocial Formulation
Components of Assessment: Biological, Psychological, Social

- Gather a history of past and current problems, signs and symptoms, and challenges
- Gather a history of past and current strengths and resources: skill based, relationship based, socially based
- Gather medical history, including surgeries, major injuries, medications past and present
- Gather mental health history, including current and prior counseling or psychiatric care
- Gather a wellness history: sleep, exercise, nutrition including supplements, self-care
- Gather a history of religious or spiritual life and its importance and relevance for the well-being of the client
Components of Assessment:
Biological, Psychological, Social

- Conduct a comprehensive mental status check
- Conduct a substance use assessment
- Gather a history of past and current suicidal and homicidal thoughts and actions
- Gather a history of past and current domestic violence and physical, emotional and/or sexual abuse
- Use appropriate standardized screening tools, operating within one’s area of competence
- Establish client goals for treatment and their vision for outcomes
Understanding 135-12-.01 and 135-12-.02 and Their Implications
GA Composite Board Rule 135-12-.01

(5) The use of these testing and assessment instruments

(a) By persons licensed as Professional Counselors, Social Workers, or Marriage and Family Therapists may include, but is not limited to, administering and interpreting educational and vocational tests; functional assessments; interest inventories; tests that evaluate marital and family functioning; and mental health symptom screening and assessment instruments that evaluate emotional, mental, behavioral, and interpersonal problems or conditions including substance abuse, health, and disability, provided that the use of these instruments does not include rendering a diagnosis or a mental or nervous disorder or illness, including but not limited to organic brain disorders, brain damage, or other neuropsychological functioning or conditions, and provided that the licensee has obtained university level training or substantially equivalent supervised experience in the use of the test or assessment instrument.
(b) By persons licensed as a Professional Counselor may also include other assessments or tests which the licensee is qualified to employ by virtue of his or her education, training, or experience, provided that the use of these instruments does not include rendering a diagnosis or a mental or nervous disorder or illness, including but not limited to organic brain disorders, brain damage, or other neuropsychological functioning or conditions.
135-12-.02 Diagnosis

(a) Persons licensed as Professional Counselors, Social Workers, or Marriage and Family Therapists who comply with this section shall be authorized to diagnose and treat mental, emotional, and behavioral disorders through the use of current classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification System of Diseases and Related Health Problems (ICD).
Requirements for Clinicians: Assessment of Disorders Outside Area of Competence

• Develop therapeutic relationship sufficient to allow for successful assessment process
• Understand enough about the disorder(s) to create provisional identification from presentation of signs and symptoms
• Identify other potential biological or psychological explanations for the presentation of signs and symptoms
• Provide appropriate psychoeducation to the client to create receptiveness for referral
• Build motivation for further assessment/treatment
• Make appropriate referral for further diagnosis/treatment
• Follow-up to make sure that client follows through
Requirements for Clinicians:
Working as Adjunct Provider of Services

• Develop therapeutic relationship sufficient to allow for successful treatment process
• Understand enough about the disorder(s) to understand the clinical record and implications of disorder for providing supportive treatment
• Identify ongoing signs and symptoms that denote changes in client status, emergence of other disorders, negative reactions to medication/treatment
• Provide appropriate ongoing psychoeducation to the client on treatment rationale
• Build motivation for treatment compliance
• Maintain appropriate coordination with other providers
Understanding 135-12-.01 and 135-12-.02 and Their Implications
GA Composite Board Rule 135-12-.01

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Section One

Assessment and Diagnosis of Neurocognitive Disorders
Key Changes from DSM-IV-TR to DSM-5
Important Reformulations of Diagnoses in the DSM-5

• Dementia and Amnestic Disorders

All diagnoses that include the term Dementia have been deleted

Amnestic Disorder (DSM-IV-TR 294.8) has been deleted

*Replaced by:*

Neurocognitive Disorder
## Neurocognitive Disorders

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<th>Code</th>
<th>Disorder</th>
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<tr>
<td>F1*.***</td>
<td>Delirium</td>
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Criteria:

A. A disturbance in attention (i.e., reduced ability to focus, sustain, and shift attention) and awareness.

B. The disturbance develops over a short period of time (hours to a few days), represents a change from baseline attention and awareness, and tends to fluctuate in severity during the course of a day.

C. An additional disturbance in cognition (e.g., memory deficit, disorientation, language, visuospatial ability, or perception).

D. The disturbances in Criteria A and C are not better explained by another preexisting, established, or evolving neurocognitive disorder and do not occur in the context of a severely reduced level of arousal, such as coma.

E. There is evidence from the history, physical examination, or laboratory findings that the disturbance is a direct physiological consequence of another medical condition, substance intoxication or withdrawal (i.e., due to a drug of abuse or to a medication), or exposure to a toxin, or is due to multiple etiologies.
Neurocognitive Disorders

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Specify whether:

**Substance intoxication delirium**: This diagnosis should be made instead of substance intoxication when the symptoms in Criteria A and C predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Code [specific substance] withdrawal delirium: 291.0 (F I0.231) alcohol; 292.0 (F11.23) opioid; 292.0 (F I3.231) sedative, hypnotic, or anxiolytic; 292.0 (F19.231) other (or unknown) substance/medication.

**Medication-induced delirium**: This diagnosis applies when the symptoms in Criteria A and C arise as a side effect of a medication taken as prescribed.

**Coding note**: The ICD-10-CM code depends on the type of medication. If the medication is an opioid taken as prescribed, the code is F11.921. If the medication is a sedative, hypnotic, or anxiolytic taken as prescribed, the code is F13.921. If the medication is an amphetamine-type or other stimulant taken as prescribed, the code is F 15.921. For medications that do not fit into any of the classes (e.g., dexamethasone) and in cases in which a substance is judged to be an etiological factor but the specific class of substance is unknown, the code is F19.921.
Neurocognitive Disorders

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**F05 Delirium due to another medical condition**: There is evidence from the history, physical examination, or laboratory findings that the disturbance is attributable to the physiological consequences of another medical condition.

**Coding note**: Include the name of the other medical condition in the name of the delirium. The other medical condition should also be coded and listed separately immediately before the delirium due to another medical condition.

**F05 Delirium due to multiple etiologies**: There is evidence from the history, physical examination, or laboratory findings that the delirium has more than one etiology (e.g., more than one etiological medical condition; another medical condition plus substance intoxication or medication side effect).

**Coding note**: Use multiple separate codes reflecting specific delirium etiologies (e.g., 572.2 [K72.90] hepatic encephalopathy, 293.0 [F05] delirium due to hepatic failure; 291.0 [F1 0.231] alcohol withdrawal delirium). Note that the etiological medical condition both appears as a separate code that precedes the delirium code and is substituted into the delirium due to another medical condition rubric.

**Specify if**:

- **Acute**: Lasting a few hours or days.
- **Persistent**: Lasting weeks or months
Neurocognitive Disorders

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Specify if:

**Hyperactive**: The individual has a hyperactive level of psychomotor activity that may be accompanied by mood lability, agitation, and/or refusal to cooperate with medical care.

**Hypoactive**: The individual has a hypoactive level of psychomotor activity that may be accompanied by sluggishness and lethargy that approaches stupor.

**Mixed level of activity**: The individual has a normal level of psychomotor activity even though attention and awareness are disturbed. Also includes individuals whose activity level rapidly fluctuates.
Neurocognitive Disorders

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<td>R41</td>
<td>Other Specified Delirium</td>
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This category applies to presentations in which symptoms characteristic of delirium 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 delirium or any of the disorders in the neurocognitive disorders diagnostic class. The other specified delirium category is used in situations in which the clinician chooses to communicate the specific reason that the presentation does not meet the criteria for delirium or any specific neurocognitive disorder. This is done by recording “other specified delirium” followed by the specific reason (e.g., “attenuated delirium syndrome”). An example of a presentation that can be specified using the “other specified” designation is the following:

Attenuated delirium syndrome: This syndrome applies in cases of delirium in which the severity of cognitive impairment falls short of that required for the diagnosis, or in which some, but not all, diagnostic criteria for delirium are met.
Neurocognitive Disorders

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This category applies to presentations in which symptoms characteristic of delirium 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 delirium or any of the disorders in the neurocognitive disorders diagnostic class. The unspecified delirium category is used in situations in which the clinician chooses not to specify the reason that the criteria are not met for delirium, and includes presentations for which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
## Major and Mild Neurocognitive Disorders

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### Criteria:

A. Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-motor, or social cognition) based on:

1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function; and
2. A substantial impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits interfere with independence in everyday activities (i.e., at a minimum, requiring assistance with complex instrumental activities of daily living such as paying bills or managing medications).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder (e.g., major depressive disorder, schizophrenia).
# Major and Mild Neurocognitive Disorders

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**Specify:**

- **Without behavioral disturbance:** If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.
- **With behavioral disturbance (specify disturbance):** If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., psychotic symptoms, mood disturbance, agitation, apathy, or other behavioral symptoms).

**Specify current severity:**

- **Mild:** Difficulties with instrumental activities of daily living (e.g., housework, managing money).
- **Moderate:** Difficulties with basic activities of daily living (e.g., feeding, dressing).
- **Severe:** Fully dependent.
Major and Mild Neurocognitive Disorders

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Criteria:

A. Evidence of modest cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual motor, or social cognition) based on:
   1. Concern of the individual, a knowledgeable informant, or the clinician that there has been a mild decline in cognitive function; and
   2. A modest impairment in cognitive performance, preferably documented by standardized neuropsychological testing or, in its absence, another quantified clinical assessment.

B. The cognitive deficits do not interfere with capacity for independence in everyday activities (i.e., complex instrumental activities of daily living such as paying bills or managing medications are preserved, but greater effort, compensatory strategies, or accommodation may be required).

C. The cognitive deficits do not occur exclusively in the context of a delirium.

D. The cognitive deficits are not better explained by another mental disorder
## Major and Mild Neurocognitive Disorders

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Specify whether due to:

- Alzheimer’s disease
- Frontotemporal lobar degeneration
- Lewy body disease
- Vascular disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson’s disease
- Huntington’s disease
- Another medical condition
- Multiple etiologies
- Unspecified
### Major and Mild Neurocognitive Disorders

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**Coding note:**
For mild neurocognitive disorder due to any of the medical etiologies listed above, code G31.84.
Do not use additional codes for the presumed etiological medical conditions.
For substance/medication-induced mild neurocognitive disorder, code based on type of substance; see “Substance/Medication-Induced Major or Mild Neurocognitive Disorder.” For unspecified mild neurocognitive disorder, code R41.9.

**Specify:**
- **Without behavioral disturbance:** If the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.
- **With behavioral disturbance (specify disturbance):** If the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., psychotic symptoms, mood disturbance, agitation, apathy, or other behavioral symptoms).
Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is insidious onset and gradual progression of impairment in one or more cognitive domains (for major neurocognitive disorder, at least two domains must be impaired).
C. Criteria are met for either probable or possible Alzheimer’s disease as follows:
   For major neurocognitive disorder: Probable Alzheimer’s disease is diagnosed if either of the following is present; otherwise, possible Alzheimer’s disease should be diagnosed.
   1. Evidence of a causative Alzheimer’s disease genetic mutation from family history or genetic testing.
   2. All three of the following are present:
      a. Clear evidence of decline in memory and learning and at least one other cognitive domain (based on detailed history or serial neuropsychological testing).
      b. Steadily progressive, gradual decline in cognition, without extended plateaus.
      c. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental disease or condition likely contributing to cognitive decline).
Major or Mild Neurocognitive Disorder Due to Alzheimer’s Disease

For mild neurocognitive disorder:
Probable Alzheimer’s disease is diagnosed if there is evidence of a causative Alzheimer’s disease genetic mutation from either genetic testing or family history.
Possible Alzheimer’s disease is diagnosed if there is no evidence of a causative Alzheimer’s disease genetic mutation from either genetic testing or family history, and all three of the following are present:
2. Steadily progressive, gradual decline in cognition, without extended plateaus.
3. No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).

D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.

Coding note: For probable major neurocognitive disorder due to Alzheimer’s disease, with behavioral disturbance, code first G30.9 Alzheimer’s disease, followed by F02.81 major neurocognitive disorder due to Alzheimer’s disease. For probable neurocognitive disorder due to Alzheimer’s disease, without behavioral disturbance, code first G30.9 Alzheimer’s disease, followed by F02.80 major neurocognitive disorder due to Alzheimer’s disease. For possible major neurocognitive disorder due to Alzheimer’s disease, without behavioral disturbance. For possible major neurocognitive disorder due to Alzheimer’s disease, code G31.9 possible major neurocognitive disorder due to Alzheimer’s disease.
Major or Mild Frontotemporal Neurocognitive Disorder

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. The disturbance has insidious onset and gradual progression.
C. Either (1) or (2):
   1. Behavioral variant:
      a. Three or more of the following behavioral symptoms:
         i. Behavioral disinhibition.
         ii. Apathy or inertia.
         iii. Loss of sympathy or empathy.
         iv. Perseverative, stereotyped or compulsive/ritualistic behavior.
         v. Hyperorality and dietary changes.
      b. Prominent decline in social cognition and/or executive abilities.
   2. Language variant:
      a. Prominent decline in language ability, in the form of speech production, word finding, object naming, grammar, or word comprehension.
D. Relative sparing of learning and memory and perceptual-motor function.
Probable frontotemporal neurocognitive disorder is diagnosed if either of the following is present; otherwise, possible frontotemporal neurocognitive disorder should be diagnosed:

1. Evidence of a causative frontotemporal neurocognitive disorder genetic mutation, from either family history or genetic testing.

2. Evidence of disproportionate frontal and/or temporal lobe involvement from neuroimaging.

E. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.
Major or Mild Frontotemporal Neurocognitive Disorder

Probable frontotemporal neurocognitive disorder is diagnosed if either of the following is present;

otherwise, possible frontotemporal neurocognitive disorder should be diagnosed:

1. Evidence of a causative frontotemporal neurocognitive disorder genetic mutation, from either
   family history or genetic testing.

2. Evidence of disproportionate frontal and/or temporal lobe involvement from neuroimaging.

Possible frontotemporal neurocognitive disorder is diagnosed if there is no evidence of a genetic mutation, and neuroimaging has not been performed.

Coding note: For probable major neurocognitive disorder due to frontotemporal lobar degeneration, with behavioral disturbance, code first G31.09 frontotemporal disease, followed by F02.81 probable major neurocognitive disorder due to frontotemporal lobar degeneration, with behavioral disturbance. For probable major neurocognitive disorder due to frontotemporal lobar degeneration, without behavioral disturbance, code first G31.09 frontotemporal disease, followed by F02.80 probable major neurocognitive disorder due to frontotemporal lobar degeneration, without behavioral disturbance
Major or Mild Neurocognitive Disorder with Lewy Bodies

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. The disorder has an insidious onset and gradual progression.
C. The disorder meets a combination of core diagnostic features and suggestive diagnostic features for either probable or possible neurocognitive disorder with Lewy bodies. For probable major or mild neurocognitive disorder with Lewy bodies, the individual has two core features, or one suggestive feature with one or more core features. For possible major or mild neurocognitive disorder with Lewy bodies, the individual has only one core feature, or one or more suggestive features.
Major or Mild Neurocognitive Disorder with Lewy Bodies

Criteria:
1. Core diagnostic features:
   a. Fluctuating cognition with pronounced variations in attention and alertness.
   b. Recurrent visual hallucinations that are well formed and detailed.
   c. Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline.
2. Suggestive diagnostic features;
   a. Meets criteria for rapid eye movement sleep behavior disorder.
   b. Severe neuroleptic sensitivity.
D. The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological disorder.
Major or Mild Neurocognitive Disorder with Lewy Bodies

Coding note:
For probable major neurocognitive disorder with Lewy bodies, with behavioral disturbance, code first G31.83 Lewy body disease, followed by F02.81 probable major neurocognitive disorder with Lewy bodies, with behavioral disturbance.
For probable major neurocognitive disorder with Lewy bodies, without behavioral disturbance, code first G31.83 Lewy body disease, followed by F02.80 probable major neurocognitive disorder with Lewy bodies, without behavioral disturbance.
For possible major neurocognitive disorder with Lewy bodies, code G31.9 possible major neurocognitive disorder with Lewy bodies. (Note: Do not use the additional code for Lewy body disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
For mild neurocognitive disorder with Lewy bodies, code G31.84. (Note: Do not use the additional code for Lewy body disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Vascular Neurocognitive Disorder

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. The clinical features are consistent with a vascular etiology, as suggested by either of the following:
   1. Onset of the cognitive deficits is temporally related to one or more cerebrovascular events.
   2. Evidence for decline is prominent in complex attention (including processing speed) and frontal-executive function.
C. There is evidence of the presence of cerebrovascular disease from history, physical examination, and/or neuroimaging considered sufficient to account for the neurocognitive deficits.
Major or Mild Vascular Neurocognitive Disorder

D. The symptoms are not better explained by another brain disease or systemic disorder.

Probable vascular neurocognitive disorder is diagnosed if one of the following is present; otherwise possible vascular neurocognitive disorder should be diagnosed:

1. Clinical criteria are supported by neuroimaging evidence of significant parenchymal injury attributed to cerebrovascular disease (neuroimaging-supported).

2. The neurocognitive syndrome is temporally related to one or more documented cerebrovascular events.

3. Both clinical and genetic (e.g., cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy) evidence of cerebrovascular disease is present.
Possible vascular neurocognitive disorder is diagnosed if the clinical criteria are met but neuroimaging is not available and the temporal relationship of the neurocognitive syndrome with one or more cerebrovascular events is not established.

Coding note: For probable major vascular neurocognitive disorder, with behavioral disturbance, code F01.51. For probable major vascular neurocognitive disorder, without behavioral disturbance, code F01.50. For possible major vascular neurocognitive disorder, with or without behavioral disturbance, code G31.9. An additional medical code for the cerebrovascular disease is not needed. For mild vascular neurocognitive disorder, code G31.84. (Note: Do not use an additional code for the vascular disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is evidence of a traumatic brain injury—that is, an impact to the head or other mechanisms of rapid movement or displacement of the brain within the skull, with one or more of the following:
   1. Loss of consciousness.
   2. Posttraumatic amnesia.
   3. Disorientation and confusion.
   4. Neurological signs (e.g., neuroimaging demonstrating injury; a new onset of seizures; a marked worsening of a preexisting seizure disorder; visual field cuts; anosmia; hemiparesis).
C. The neurocognitive disorder presents immediately after the occurrence of the traumatic brain injury or immediately after recovery of consciousness and persists past the acute post-injury period.
Major or Mild Neurocognitive Disorder Due to Traumatic Brain Injury

Coding note:

For major neurocognitive disorder due to traumatic brain injury, with behavioral disturbance: First code S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela; followed by F02.81 major neurocognitive disorder due to traumatic brain injury, with behavioral disturbance.

For major neurocognitive disorder due to traumatic brain injury, without behavioral disturbance: First code S06.2X9S diffuse traumatic brain injury with loss of consciousness of unspecified duration, sequela; followed by F02.80 major neurocognitive disorder due to traumatic brain injury, without behavioral disturbance.

For mild neurocognitive disorder due to traumatic brain injury, code 331.83 (G31.84). (Note: Do not use the additional code for traumatic brain injury. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Substance/ Medication Induced Major or Mild Neurocognitive Disorder

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. The neurocognitive impairments do not occur exclusively during the course of a delirium and persist beyond the usual duration of intoxication and acute withdrawal.
C. The involved substance or medication and duration and extent of use are capable of producing the neurocognitive impairment.
D. The temporal course of the neurocognitive deficits is consistent with the timing of substance or medication use and abstinence (e.g., the deficits remain stable or improve after a period of abstinence).
E. The neurocognitive disorder is not attributable to another medical condition or is not better explained by another mental disorder.

Specify if: Persistent: Neurocognitive impairment continues to be significant after an extended period of abstinence.
Major or Mild Neurocognitive Disorder Due to HIV Infection

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is documented infection with human immunodeficiency virus (HIV).
C. The neurocognitive disorder is not better explained by non-HIV conditions, including secondary brain diseases such as progressive multifocal leukoencephalopathy or cryptococcal meningitis.
D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by a mental disorder.

Coding note:
For major neurocognitive disorder due to HIV infection, with behavioral disturbance, code first B20 HIV infection, followed by F02.81 major neurocognitive disorder due to HIV infection, with behavioral disturbance.
For major neurocognitive disorder due to HIV infection, without behavioral disturbance, code first B20 HIV infection, followed by F02.80 major neurocognitive disorder due to HIV infection, without behavioral disturbance.
For mild neurocognitive disorder due to HIV infection, code G31.84. (Note: Do not use the additional code for HIV infection. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Prion Disease

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is insidious onset, and rapid progression of impairment is common.
C. There are motor features of prion disease, such as myoclonus or ataxia, or biomarker evidence.
D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Coding note:
For major neurocognitive disorder due to prion disease, with behavioral disturbance, code first A81.9 prion disease, followed by F02.81 major neurocognitive disorder due to prion disease, with behavioral disturbance.

For major neurocognitive disorder due to prion disease, without behavioral disturbance, code first A81.9 prion disease, followed by F02.80 major neurocognitive disorder due to prion disease, without behavioral disturbance.

For mild neurocognitive disorder due to prion disease, code G31.84. (Note: Do not use the additional code for prion disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. The disturbance occurs in the setting of established Parkinson’s disease.
C. There is insidious onset and gradual progression of impairment.
D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Major or mild neurocognitive disorder probably due to Parkinson’s disease should be diagnosed if 1 and 2 are both met. Major or mild neurocognitive disorder possibly due to Parkinson’s disease should be diagnosed if 1 or 2 is met:

1. There is no evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).
2. The Parkinson’s disease clearly precedes the onset of the neurocognitive disorder.
Major or Mild Neurocognitive Disorder Due to Parkinson’s Disease

**Coding note:** For major neurocognitive disorder probably due to Parkinson’s disease, with behavioral disturbance, code first G20 Parkinson’s disease, followed by F02.81 major neurocognitive disorder probably due to Parkinson’s disease, with behavioral disturbance.

For major neurocognitive disorder probably due to Parkinson’s disease, without behavioral disturbance, code first G20 Parkinson’s disease, followed by F02.80 major neurocognitive disorder probably due to Parkinson’s disease, without behavioral disturbance.

For major neurocognitive disorder possibly due to Parkinson’s disease, code G31.9 major neurocognitive disorder possibly due to Parkinson’s disease. (Note: Do not use the additional code for Parkinson’s disease. Behavioral disturbance cannot be coded but should still be indicated in writing.) For mild neurocognitive disorder due to Parkinson’s disease, code G31.84. (Note: Do not use the additional code for Parkinson’s disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Huntington’s Disease

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is insidious onset and gradual progression.
C. There is clinically established Huntington’s disease, or risk for Huntington’s disease based on family history or genetic testing.
D. The neurocognitive disorder is not attributable to another medical condition and is not better explained by another mental disorder.

Coding note: For major neurocognitive disorder due to Huntington’s disease, with behavioral disturbance, code first G10 Huntington’s disease, followed by F02.81 major neurocognitive disorder due to Huntington’s disease, with behavioral disturbance. For major neurocognitive disorder due to Huntington’s disease, without behavioral disturbance, code first G10 Huntington’s disease, followed by F02.80 major neurocognitive disorder due to Huntington’s disease, without behavioral disturbance. For mild neurocognitive disorder due to Huntington’s disease, code G31.84. (Note: Do not use the additional code for Huntington’s disease. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Another Medical Condition

Criteria:
A. The criteria are met for major or mild neurocognitive disorder.
B. There is evidence from the history, physical examination, or laboratory findings that the neurocognitive disorder is the pathophysiological consequence of another medical condition.
C. The cognitive deficits are not better explained by another mental disorder or another specific neurocognitive disorder (e.g., Alzheimer’s disease, HIV infection).

Coding note: For major neurocognitive disorder due to another medical condition, with behavioral disturbance, code first the other medical condition, followed by the major neurocognitive disorder due to another medical condition, with behavioral disturbance (e.g., 340 [G35] multiple sclerosis, F02.81 major neurocognitive disorder due to multiple sclerosis, with behavioral disturbance).
For major neurocognitive disorder due to another medical condition, without behavioral disturbance, code first the other medical condition, followed by the major neurocognitive disorder due to another medical condition, without behavioral disturbance (e.g., 340 [G35] multiple sclerosis, F02.80 major neurocognitive disorder due to multiple sclerosis, without behavioral disturbance).
For mild neurocognitive disorder due to another medical condition, code G31.84. (Note: Do not use the additional code for the other medical condition. Behavioral disturbance cannot be coded but should still be indicated in writing.)
Major or Mild Neurocognitive Disorder Due to Multiple Etiologies

Criteria:

A. The criteria are met for major or mild neurocognitive disorder.

B. There is evidence from the history, physical examination, or laboratory findings that the neurocognitive disorder is the pathophysiological consequence of more than one etiological process, excluding substances (e.g., neurocognitive disorder due to Alzheimer's disease with subsequent development of vascular neurocognitive disorder). Note: Please refer to the diagnostic criteria for the various neurocognitive disorders due to specific medical conditions for guidance on establishing the particular etiologies.

C. The cognitive deficits are not better explained by another mental disorder and do not occur exclusively during the course of a delirium.
Major or Mild Neurocognitive Disorder Due to Multiple Etiologies

Coding note: For major neurocognitive disorder due to multiple etiologies, with behavioral disturbance, code F02.81; for major neurocognitive disorder due to multiple etiologies, without behavioral disturbance, code F02.80. All of the etiological medical conditions (with the exception of vascular disease) should be coded and listed separately immediately before major neurocognitive disorder due to multiple etiologies (e.g., G30.9 Alzheimer’s disease; G31.83 Lewy body disease; F02.81 major neurocognitive disorder due to multiple etiologies, with behavioral disturbance). When a cerebrovascular etiology is contributing to the neurocognitive disorder, the diagnosis of vascular neurocognitive disorder should be listed in addition to major neurocognitive disorder due to multiple etiologies. For example, for a presentation of major neurocognitive disorder due to both Alzheimer’s disease and vascular disease, with behavioral disturbance, code the following: G30.9 Alzheimer’s disease; F02.81 major neurocognitive disorder due to multiple etiologies, with behavioral disturbance; F0I .51 major vascular neurocognitive disorder, with behavioral disturbance. For mild neurocognitive disorder due to multiple etiologies, code G31.84. (Note: Do not use the additional codes for the etiologies. Behavioral disturbance cannot be coded but should still be indicated in writing.)
DSM-5 & ICD-10

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Section One

Assessment and Diagnosis of Schizophrenia Spectrum and Other Psychotic Disorders
I Want to Hear From You . . .
Key Changes from DSM-IV-TR to DSM-5
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.
The following specifiers apply to Schizophrenia Spectrum and Other Psychotic Disorders where indicated:

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

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

c. **Specify current severity of delusions, hallucinations, disorganized speech, abnormal motor behavior, negative symptoms, impaired role, depression, and manic episodes:**

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>301.22 (F21)</td>
<td>Schizotypal (Personality) (90)</td>
</tr>
<tr>
<td>297.1 (F22)</td>
<td>Delusional Disorder (90)</td>
</tr>
</tbody>
</table>

**Specify whether:**
- Erotomanic type, Grandiose type, Jealous type, Somatic type, Mixed type, Unspecified type.

**Specify if:** With bizarre content.
**KEY**

for Changes

- Removed from the manual = red with a strike through
- *Moved from one chapter or section to another in the DSM-5* = light blue italic
- **New to the DSM-5** = lavender with an underline
Organization of the

**DSM-IV** vs. **DSM-5**

- Disorders 1<sup>st</sup> Dx in Infancy, Childhood, Adol.
- Psychotic Disorders
- Mood Disorders
- Mood Disorders
- Anxiety Disorders
- Anxiety Disorders
- Anxiety Disorders

**DSM-5**

- Neurodevelopmental Disorders
- Schizophrenia Spectrum & Other Psychotic Disorders
- Bipolar & Related Disorders
- Depressive Disorders
- Anxiety Disorders
- OC & Related Disorders
- Trauma & Stressor-Related Disorders
2. Schizophrenia Spectrum and Other Psychotic Disorders

- Schizotypal Personality Disorder (*ICD has in same chapter*)
- Delusional Disorder (It doesn’t have to be non-bizarre anymore)
- Brief Psychotic Disorder (< 1 mo)
- Schizotypal Disorder (1-6 mos)
- Schizophrenia (> 6 mos)
- Schizoaffective Disorder
- *Attenuated Psychosis - Conditions for Further Study*
Important Reformulations of Diagnoses in the DSM-5

• Schizophrenia

1) Bizarre delusions and Schneiderian first-rank auditory hallucinations no longer stand as special symptoms: where either one of these standing alone will suffice to meet diagnostic requirements for Schizophrenia under Criteria A (Presence of: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms like diminished emotional expressiveness or avolition). A minimum of two symptoms in category A is now required.

2) At least one of the following three core symptoms must be present in order to warrant a diagnosis of schizophrenia under the DSM-5: delusions, hallucinations, and disorganized speech.


Important Reformulations of Diagnoses in the DSM-5

• Delusional Disorder

1) It is no longer required that delusions be non-bizarre in order to meet Criteria A for this disorder.
2) DSM-5 “no longer separates delusional disorder from shared delusional disorder”.
Delusional Disorder

- New exclusion criterion for delusional disorder, which states that the symptoms “must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs.”
Reformulated: Schizophrenia

• Removal of special symptoms

1) Bizarre delusions and Shneiderian first-rank auditory hallucinations no longer stand as special symptoms: where either one of these standing alone will suffice to meet diagnostic requirements for Schizophrenia under Criteria A (Presence of: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms like diminished emotional expressiveness or avolition). A minimum of two symptoms in category A is now required.
Reformulated: Schizophrenia

• **Requirement for one of three core symptoms**

2) At least one of the following three core symptoms must be present in order to warrant a diagnosis of schizophrenia under the DSM-5: delusions, hallucinations, and disorganized speech.
Schizophrenia Spectrum and Related Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F22</td>
<td>Delusional Disorder</td>
<td></td>
</tr>
</tbody>
</table>

Criteria:

A. The presence of one (or more) delusions with a duration of 1 month or longer.
B. Criterion A for schizophrenia has never been met. Note: Hallucinations, if present, are not prominent and are related to the delusional theme (e.g., the sensation of being infested with insects associated with delusions of infestation).
C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behavior is not obviously bizarre or odd.
D. If manic or major depressive episodes have occurred, these have been brief relative to the duration of the delusional periods.
E. The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.
Specify whether:

**Erotomanic type:** This subtype applies when the central theme of the delusion is that another person is in love with the individual.

**Grandiose type:** This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

**Jealous type:** This subtype applies when the central theme of the individual’s delusion is that his or her spouse or lover is unfaithful.

**Persecutory type:** This subtype applies when the central theme of the delusion involves the individual’s belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals.

**Somatic type:** This subtype applies when the central theme of the delusion involves bodily functions or sensations.

**Mixed type:** This subtype applies when no one delusional theme predominates. Unspecified type: This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).
### Schizophrenia Spectrum and Related Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F22</td>
<td>Delusional Disorder</td>
<td></td>
</tr>
</tbody>
</table>

**Specify if:**

**With bizarre content:** Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., an individual’s belief that a stranger has removed his or her internal organs and replaced them with someone else’s).

**Specify if:** The following specifiers are only to be used after a 1-year duration of the disorder:

- **First episode, currently in acute episode:** First manifestation meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the criteria are fulfilled.
- **First episode, currently in partial remission:** Partial remission is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.
- **First episode, currently in full remission:** Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.
- **Multiple episodes, currently in acute episode**
- **Multiple episodes, currently in partial remission**
- **Multiple episodes, currently in full remission**
- **Continuous:** Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.
- **Unspecified**
Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”)

Note: Diagnosis of delusional disorder can be made without using this severity specifier.
Schizophrenia Spectrum and Related Disorders

Criteria:
A. Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment or incoherence).
   4. Grossly disorganized or catatonic behavior.
   Note: Do not include a symptom if it is a culturally sanctioned response.
B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
C. The disturbance is not better explained by major depressive or bipolar disorder with psychotic features or another psychotic disorder such as schizophrenia or catatonia, and is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F23</td>
<td>Brief Psychotic Disorder</td>
<td></td>
</tr>
</tbody>
</table>
Specify if:
With marked stressor(s) (brief reactive psychosis): If symptoms occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture.
Without marked stressor(s): If symptoms do not occur in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the individual’s culture.
With postpartum onset: If onset is during pregnancy or within 4 weeks postpartum.
Specify if: With catatonia. Coding note: Use additional code F06.1 catatonia associated with brief psychotic disorder to indicate the presence of the comorbid catatonia.
Specify current severity:
Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”) Note: Diagnosis of brief psychotic disorder can be made without using this severity specifier.
Schizophrenia Spectrum and Related Disorders

Criteria:

A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment or incoherence).
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. An episode of the disorder lasts at least 1 month but less than 6 months. When the diagnosis must be made without waiting for recovery, it should be qualified as “provisional.”

C. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either
   1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or
   2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

D. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F20.81</td>
<td>Schizophreniform Disorder</td>
<td></td>
</tr>
</tbody>
</table>
Specify if:

With good prognostic features: This specifier requires the presence of at least two of the following features:
onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning; confusion or perplexity: good premorbid social and occupational functioning; and absence of blunted or flat affect.

Without good prognostic features: This specifier is applied if two or more of the above features have not been present.

Specify if: With catatonia. Coding note: Use additional code F06.1 catatonia associated with schizophreniform disorder to indicate the presence of the comorbid catatonia.

Specify current severity: Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). Note: Diagnosis of schizophreniform disorder can be made without using this severity specifier.
Schizophrenia

- Schizophrenia subtypes have been dropped in the DSM-5 because of their “limited diagnostic stability, low reliability, and poor validity,” according to the APA. (The old DSM-IV had specified the following schizophrenia subtypes: paranoid, disorganized, catatonic, undifferentiated, and residual type.)
- DSM-5 Eliminated the “special attribution of bizarre delusions and the Schneiderian first-rank auditory hallucinations (e.g., two or more voices). In DSM-IV, one of these eliminated the need for two items on Criterion A.
Schizophrenia – DSM-5
(Cont.)

A. Two (or more) of the following, each present for a significant portion of time during a 1 month period (or less if successfully treated). At least one of these should include 1–3.

1. Delusions
2. Hallucinations
3. Disorganized speech
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (diminished emotional expression or avolition)
Schizophrenia Spectrum and Related Disorders

Criteria:
A. Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):
   1. Delusions.
   2. Hallucinations.
   3. Disorganized speech (e.g., frequent derailment or incoherence).
   4. Grossly disorganized or catatonic behavior.
   5. Negative symptoms (i.e., diminished emotional expression or avolition).
B. For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).
C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>F20.9</td>
<td>Schizophrenia</td>
<td></td>
</tr>
</tbody>
</table>
D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

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.

F. If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Specify if: With catatonia. Coding note: Use additional code F06.1 catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia.

Specify current severity: Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”) Note: Diagnosis of schizophrenia can be made without using this severity specifier.
Clinicain-Rated Dimensions of Psychosis
Symptom of Severity pages 743-744

I. Hallucinations
II. Delusions
III. Disorganized speech
IV. Abnormal psychomotor behavior
V. Negative Symptoms (restricted emotional expression or avolition)
VI. Impaired cognition
VII. Depression
VIII. Mania
<table>
<thead>
<tr>
<th>Domain</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Hallucinations</td>
<td>Not present</td>
<td>Equivocal (severity or duration not sufficient to be considered psychosis)</td>
<td>Present, but mild (little pressure to act upon voices, not very bothered by voices)</td>
<td>Present and moderate (some pressure to respond to voices, or is somewhat bothered by voices)</td>
<td>Present and severe (severe pressure to respond to voices)</td>
</tr>
<tr>
<td>II. Delusions</td>
<td>Not present</td>
<td>Equivocal (severity or duration not sufficient to be considered psychosis)</td>
<td>Present, but mild (little pressure to act upon delusional beliefs, not very bothered by beliefs)</td>
<td>Present and moderate (some pressure to act upon beliefs, or is somewhat bothered by beliefs)</td>
<td>Present and severe (severe pressure to respond to voices, or is very bothered by voices)</td>
</tr>
<tr>
<td>III. Disorganized speech</td>
<td>Not present</td>
<td>Equivocal (severity or duration not sufficient to be considered disorganization)</td>
<td>Present, but mild (some difficulty following speech)</td>
<td>Present and moderate (speech often difficult to follow)</td>
<td>Present and severe (speech almost impossible to follow)</td>
</tr>
<tr>
<td>IV. Abnormal psychomotor behavior</td>
<td>Not present</td>
<td>Equivocal (severity or duration not sufficient to be considered abnormal psychomotor behavior)</td>
<td>Present, but mild (occasional abnormal or bizarre motor behavior or catatonia)</td>
<td>Present and moderate (frequent abnormal or bizarre motor behavior or catatonia)</td>
<td>Present and severe (abnormal or motor behavior, or catatonia absent)</td>
</tr>
<tr>
<td>V. Negative symptoms (restricted emotional expression or avolition)</td>
<td>Not present</td>
<td>Equivocal decrease in facial expressivity, prosody, gestures, or self-initiated behavior</td>
<td>Present, but mild decrease in facial expressivity, prosody, gestures, or self-initiated behavior</td>
<td>Present and moderate decrease in facial expressivity, prosody, gestures, or self-initiated behavior</td>
<td>Present and severe decrease in expressivity, prosody, gestures, or self-initiated behavior</td>
</tr>
<tr>
<td>Domain</td>
<td>0</td>
<td>1</td>
<td>2</td>
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<tr>
<td>VI. Impaired cognition</td>
<td>□ Not present</td>
<td>□ Equivocal (cognitive function not clearly outside the range expected for age or SES; i.e., within 0.5 SD of mean)</td>
<td>□ Present, but mild (some reduction in cognitive function; below expected for age and SES, 0.5–1 SD from mean)</td>
<td>□ Present and moderate (clear reduction in cognitive function; below expected for age and SES, 1–2 SD from mean)</td>
<td>□ Present and severe (severe reduction in cognitive function; below expected for age and SES, &gt;2 SD from mean)</td>
</tr>
<tr>
<td>VII. Depression</td>
<td>□ Not present</td>
<td>□ Equivocal (occasionally feels sad, down, depressed, or hopeless; concerned about having failed someone or at something but not preoccupied)</td>
<td>□ Present, but mild (frequent periods of feeling very sad, down, moderately depressed, or hopeless; concerned about having failed someone or at something, with some preoccupation)</td>
<td>□ Present and moderate (frequent periods of deep depression or hopelessness; preoccupation with guilt, having done wrong)</td>
<td>□ Present and severe (deeply depressed or hopeless daily; delusional guilt or unreasonable self-reproach grossly out of proportion to circumstances)</td>
</tr>
<tr>
<td>VIII. Mania</td>
<td>□ Not present</td>
<td>□ Equivocal (occasional elevated, expansive, or irritable mood or some restlessness)</td>
<td>□ Present, but mild (frequent periods of somewhat elevated, expansive, or irritable mood or restlessness)</td>
<td>□ Present and moderate (frequent periods of extensively elevated, expansive, or irritable mood or restlessness)</td>
<td>□ Present and severe (daily and extensively elevated, expansive, or irritable mood or restlessness)</td>
</tr>
</tbody>
</table>

Note: SD = standard deviation; SES = socioeconomic status.
• First identified in 1860’s, by early 1900’s made a major Schizophrenia subtype

• Through first three DSMs, Catatonia was strictly Schizophrenia

• In the 1970’s it became apparent Catatonia was associated with neurological disorders as well as major mood disorders (particularly during Mania)
Catatonia Revisited
(Adapted from Bogenberger, 2013)

- DSM-IV allowed for both of these diagnosis specifiers
- DSM-5 notes that Catatonia is:
  - Under recognized
  - Present in Schizophreniform, Schizoaffective, Brief and Substance-induced Psychosis
  - Also present in Autism, Bipolar, and Depression
  - Responsive to Benzodiazepines and ECT
Catatonia Specifier

• Three or more of the following sx$s$:
  1. Stupor
  2. Catalepsy (posture held against gravity)
  3. Waxy flexibility
  4. Mutism
  5. Negativism (unresponsive)
  6. Posturing
  7. Mannerism
  8. Stereotypy
  9. Agitation
  10. Grimacing
  11. Echolalia
  12. Echopraxia
Specify if: The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: Partial remission is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and at least one relapse).

Multiple episodes, currently in partial remission
Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified
Schizoaffective Disorder

- Criterion A of Schizophrenia is concurrent with a major mood episode.
- Major mood episode must be present for a majority (vs. DSM-IV’s “substantial portion”) of the time the disorder has been present in the person.
- Still has DSM-IV’s Criterion B:
  - Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic – mixed is gone) during the lifetime duration of the illness.
Schizoaffective Disorder

Criteria:
A. An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia. **Note:** The major depressive episode must include Criterion A1: Depressed mood.

B. Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

C. Symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness.

D. The disturbance is not attributable to the effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

Specify whether: F25.0 Bipolar type: This subtype applies if a manic episode is part of the presentation. Major depressive episodes may also occur. F25.1 Depressive type: This subtype applies if only major depressive episodes are part of the presentation. Specify if: With catatonia. **Coding note:** Use additional code F06.1 catatonia associated with schizoaffective disorder to indicate the presence of the comorbid catatonia.
Schizoaffective Disorder

**Specify if**: The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meeting the defining diagnostic symptom and time criteria. An acute episode is a time period in which the symptom criteria are fulfilled.

First episode, currently in partial remission: Partial remission is a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: Full remission is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be determined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods being very brief relative to the overall course.

Unspecified
Schizoaffective Disorder

Specify current severity:
Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 5 (present and severe). Note: Diagnosis of schizoaffective disorder can be made without using this severity specifier.
Substance/ Medication Induced Psychotic Disorder

Criteria:
A. Presence of one or both of the following symptoms:
   1. Delusions.
   2. Hallucinations.

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 a psychotic disorder that is not substance/medication-induced. Such evidence of an independent psychotic disorder could include the following:
   The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication: or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes).
Substance/ Medication Induced Psychotic Disorder

D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms in Criterion A predominate in the clinical picture and when they are sufficiently severe to warrant clinical attention.

Specify if: With onset during intoxication: If the criteria are met for intoxication with the substance and the symptoms develop during intoxication. With onset during withdrawal: If the criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, withdrawal.

Specify current severity: Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe).

Note: Diagnosis of substance/medication-induced psychotic disorder can be made without using this severity specifier.
Psychotic Disorder Due to Another Medical Condition

Criteria:

A. Prominent hallucinations or delusions.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify whether: Code based on predominant symptom: F06.2 With delusions: If delusions are the predominant symptom. F06.0 With hallucinations: If hallucinations are the predominant symptom.
Psychotic Disorder Due to Another Medical Condition

**Coding note**: Include the name of the other medical condition in the name of the mental disorder (e.g., F06.2 psychotic disorder due to malignant lung neoplasm, with delusions). The other medical condition should be coded and listed separately immediately before the psychotic disorder due to the medical condition (e.g., C34.90 malignant lung neoplasm; F06.2 psychotic disorder due to malignant lung neoplasm, with delusions).

**Specify current severity**: Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, abnormal psychomotor behavior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter “Assessment Measures.”) **Note**: Diagnosis of psychotic disorder due to another medical condition can be made without using this severity specifier.
## Schizophrenia and Other Psychotic Disorders

<table>
<thead>
<tr>
<th>Code</th>
<th>Disorder</th>
<th>Category</th>
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</thead>
<tbody>
<tr>
<td>F06.1</td>
<td>Catatonia Associated with Another Mental Disorder</td>
<td>Catatonia</td>
</tr>
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</table>

**Criteria:**

A. The clinical picture is dominated by three (or more) of the following symptoms:
   1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
   2. Catalepsy (i.e., passive induction of a posture held against gravity).
   3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
   4. Mutism (i.e., no, or very little, verbal response [exclude if known aphasia]).
   5. Negativism (i.e., opposition or no response to instructions or external stimuli).
   6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
   7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
   8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
   9. Agitation, not influenced by external stimuli.
   11. Echolalia (i.e., mimicking another’s speech).
   12. Echopraxia (i.e., mimicking another’s movements).

**Coding note:** Indicate the name of the associated mental disorder when recording the name of the condition (i.e., F06.1 catatonia associated with major depressive disorder). Code first the associated mental disorder (e.g., neurodevelopmental disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or other mental disorder) (e.g., F25.1 schizoaffective disorder, depressive type; F06.1 catatonia associated with schizoaffective disorder).
Schizophrenia and Other Psychotic Disorders

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<tbody>
<tr>
<td>F06.1</td>
<td>Catatonia Disorder Due to Another Medical Condition</td>
<td>Catatonia</td>
</tr>
</tbody>
</table>

Criteria:

A. The clinical picture is dominated by three (or more) of the following symptoms:
   1. Stupor (i.e., no psychomotor activity; not actively relating to environment).
   2. Catalepsy (i.e., passive induction of a posture held against gravity).
   3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner).
   4. Mutism (i.e., no, or very little, verbal response [exclude if known aphasia]).
   5. Negativism (i.e., opposition or no response to instructions or external stimuli).
   6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity).
   7. Mannerism (i.e., odd, circumstantial caricature of normal actions).
   8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements).
   9. Agitation, not influenced by external stimuli.
  11. Echolalia (i.e., mimicking another’s speech).
  12. Echopraxia (i.e., mimicking another’s movements).
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

C. The disturbance is not better explained by another mental disorder (e.g., a manic episode).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**Coding note**: Include the name of the medical condition in the name of the mental disorder (e.g., F06.1 catatonic disorder due to hepatic encephalopathy). The other medical condition should be coded and listed separately immediately before the catatonic disorder due to the medical condition (e.g., K71.90 hepatic encephalopathy; F06.1 catatonic disorder due to hepatic encephalopathy).
Unspecified Catatonia

This category applies to presentations in which symptoms characteristic of catatonia cause clinically significant distress or impairment in social, occupational, or other important areas of functioning but either the nature of the underlying mental disorder or other medical condition is unclear, full criteria for catatonia are not met, or there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).

Coding note: Code first R29.818 other symptoms involving nervous and musculoskeletal systems, followed by F06.1 unspecified catatonia.
Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (F28)

This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic 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 schizophrenia spectrum and other psychotic disorders diagnostic class. The other specified schizophrenia spectrum and other psychotic 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 schizophrenia spectrum and other psychotic disorder. This is done by recording “other specified schizophrenia spectrum and other psychotic disorder” followed by the specific reason (e.g., “persistent auditory hallucinations”).
Examples of presentations that can be specified using the “other specified” designation include the following:

1. Persistent auditory hallucinations occurring in the absence of any other features.
2. Delusions with significant overlapping mood episodes: This includes persistent delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance (such that the criterion stipulating only brief mood disturbance in delusional disorder is not met).
3. Attenuated psychosis syndrome: This syndrome is characterized by psychotic-like symptoms that are below a threshold for full psychosis (e.g., the symptoms are less severe and more transient, and insight is relatively maintained).
4. Delusional symptoms in partner of individual with delusional disorder: In the context of a relationship, the delusional material from the dominant partner provides content for delusional belief by the individual who may not otherwise entirely meet criteria for delusional disorder.
Unspecified Schizophrenia Spectrum and Other Psychotic Disorders (F29)

This category applies to presentations in which symptoms characteristic of a schizophrenia spectrum and other psychotic 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 schizophrenia spectrum and other psychotic disorders diagnostic class. The unspecified schizophrenia spectrum and other psychotic 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 schizophrenia spectrum and other psychotic disorder, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).
Section One

Assessment and Diagnosis of Bipolar and Related Disorders
Key Changes from DSM-IV-TR to DSM-5
3. Bipolar & Related Disorders

• Bipolar I Disorder

• Bipolar II Disorder

• Cyclothymic Disorder

• No more Mixed Episode, but added new specifier - “with mixed features”
Important Reformulations of Diagnoses in the DSM-5

• Bi-Polar Disorder and Depressive Disorders

1) A new specifier has been added to accommodate circumstances in which the full criteria for the combination of mania and major depression are not present, but where major depression is present with some features of mania or hypomania, or when mania or hypomania predominate in conjunction with some depressive features. This specifier is “With mixed features”.
Important Reformulations of Diagnoses in the DSM-5

• Bi-Polar Disorder and Depressive Disorders

2) A new specifier, “With anxious distress”, has been added to the list of potential specifiers under Bipolar Disorder and under Depressive Disorders. This is meant to clarify the additional presence of anxiety over and above what occurs as a manifestation of the Bipolar Disorder or the Major Depression or Persistent Depressive Disorder.
Reformulated: Bi-Polar Disorder and Depressive Disorders

• New Specifiers: With anxious distress

1) A new specifier, “With anxious distress”, has been added to the diagnosis of bipolar disorder or major depression to clarify the additional presence of anxiety over and above what occurs as a manifestation of the Bipolar Disorder or the Major Depression or Persistent Depressive Disorder.
Bipolar & Related Disorders

• To enhance the accuracy of diagnosis and facilitate earlier detection in clinical settings, Criterion A for manic and hypomanic episodes now includes an emphasis on changes in activity and energy as well as mood.
Bipolar and Related Disorders

Bipolar and related disorders are separated from the depressive disorders in DSM-5 and placed between the chapters on schizophrenia spectrum and other psychotic disorders and depressive disorders in recognition of their place as a bridge between the two diagnostic classes in terms of symptomatology, family history, and genetics. The diagnoses included in this chapter are bipolar I disorder, bipolar II disorder, cyclothymic disorder, substance/medication-induced bipolar and related disorder, bipolar and related disorder due to another medical condition, other specified bipolar and related disorder, and unspecified bipolar and related disorder.
Bipolar I Disorder

Criteria:
For a diagnosis of bipolar I disorder, it is necessary to meet the following criteria for a manic episode. The manic episode may have been preceded by and may be followed by hypomanic or major depressive episodes.

Manic Episode
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least 1 week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e., purposeless non-goal-directed activity).
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
Bipolar I Disorder

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment) or to another medical condition. Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and, therefore, a bipolar I diagnosis. Note: Criteria A-D constitute a manic episode. At least one lifetime manic episode is required for the diagnosis of bipolar I disorder.

Hypomanic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms (four if the mood is only irritable) have persisted, represent a noticeable change from usual behavior, and have been present to a significant degree:
Bipolar I Disorder

1. Inflated self-esteem or grandiosity.
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
3. More talkative than usual or pressure to keep talking.
4. Flight of ideas or subjective experience that thoughts are racing.
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).
Bipolar I Disorder

**Note:** A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis. Note: Criteria A-'F constitute a hypomanic episode. Hypomanic episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder.
Bipolar I Disorder

Major Depressive Episode

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, or 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.)
Bipolar I Disorder

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.
Bipolar I Disorder

C. The episode is not attributable to the physiological effects of a substance or another medical condition.

Note: Criteria A-C constitute a major depressive episode. Major depressive episodes are common in bipolar I disorder but are not required for the diagnosis of bipolar I disorder. 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.
Bipolar I Disorder

A. Criteria have been met for at least one manic episode (Criteria A-D under “Manic Episode” above).

B. The occurrence of the manic and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

**Coding and Recording Procedures**: The diagnostic code for bipolar I disorder is based on type of current or most recent episode and its status with respect to 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 manic or major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a manic, hypomanic, or major depressive episode.

**In recording the name of a diagnosis**, terms should be listed in the following order: bipolar I disorder, type of current or most recent episode, severity/psychotic/remission specifiers, followed by as many specifiers without codes as apply to the current or most recent episode.
Bipolar Specifiers
(pp. 149-154)

- With anxious distress
- With mixed features
- With rapid cycling
- With melancholic features
- With atypical features
- With mood-congruent psychotic features
- With mood-incongruent psychotic features
- With catatonia
- **With peripartum onset** (during pregnancy or 4 wks after)
- With seasonal pattern
Bipolar II Disorder (F 31.81)

Criteria:
For a diagnosis of bipolar II disorder, it is necessary to meet the following criteria for a current or past hypomanic episode and the following criteria for a current or past major depressive episode:

**Hypomanic Episode**
A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least 4 consecutive days and present most of the day, nearly every day.

B. During the period of mood disturbance and increased energy and activity, three (or more) of the following symptoms have persisted (four if the mood is only irritable), represent a noticeable change from usual behavior, and have been present to a significant degree:
   1. Inflated self-esteem or grandiosity.
   2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep).
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
   6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation.
   7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
Bipolar II Disorder (F 31.81)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the individual when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization. If there are psychotic features, the episode is, by definition, manic.

F. The episode is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment). Note: A full hypomanic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at a fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for hypomanic episode diagnosis. However, caution is indicated so that one or two symptoms (particularly increased irritability, edginess, or agitation following antidepressant use) are not taken as sufficient for diagnosis of a hypomanic episode, nor necessarily indicative of a bipolar diathesis.
Bipolar II Disorder (F 31.81)

Major Depressive Episode

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 a medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, or 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.)
Bipolar II Disorder (F 31.81)

Major Depressive Episode

- 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, a suicide attempt, or a specific plan for committing suicide.
Bipolar II Disorder (F 31.81)

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 another medical condition. Note: Criteria A-C above constitute 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 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.
Bipolar II Disorder

A. Criteria have been met for at least one hypomanic episode (Criteria A-F under “Hypomanic Episode” above) and at least one major depressive episode (Criteria A-C under “Major Depressive Episode” above).

B. There has never been a manic episode.

C. The occurrence of the hypomanic episode(s) and major depressive episode(s) is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder.

D. The symptoms of depression or the unpredictability caused by frequent alternation between periods of depression and hypomania causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Bipolar II Disorder (F 31.81)

Coding and Recording Procedures
Bipolar II disorder has one diagnostic code: F31.81. Its status with respect to current severity, presence of psychotic features, course, and other specifiers cannot be coded but should be indicated in writing (e.g., F31.81 bipolar II disorder, current episode depressed, moderate severity, with mixed features; F31.81 bipolar II disorder, most recent episode depressed, in partial remission).
Specify current or most recent episode: Hypomanic or Depressed

Specify if:
With anxious distress
With mixed features
With rapid cycling
With mood-congruent psychotic features
With mood-incongruent psychotic features
With catatonia
Bipolar II Disorder (F 31.81)

Coding note: Use additional code F06.1. With peripartum onset  With seasonal pattern: Applies only to the pattern of major depressive episodes.

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

Specify severity if full criteria for a mood episode are currently met:
Mild
Moderate
Severe
Cyclothymic Disorder

- In cyclothymia, moods fluctuate from mild depression to hypomania symptoms and back again. In most people, the pattern is irregular and unpredictable. Hypomanic or depressive symptoms can last for days or weeks. In between up and down moods, a person might have normal moods for more than a month -- or may cycle continuously from hypomanic to depressed symptoms, with no normal period in between.
Cyclothymic Disorder (Cont.)

• Compared with more serious mood disorders, the mood symptoms of cyclothymia are mild. Depressive symptoms in cyclothymic disorder never reach the criteria for major depression. Elevated mood never reaches the definition for hypomania.
Cyclothymic Disorder (F 34.0)

Criteria:
A. For at least 2 years (at least 1 year in children and adolescents) there have been numerous periods with hypomanic symptoms that do not meet criteria for a hypomanic episode and numerous periods with depressive symptoms that do not meet criteria for a major depressive episode.
B. During the above 2-year period (1 year in children and adolescents), the hypomanic and depressive periods have been present for at least half the time and the individual has not been without the symptoms for more than 2 months at a time.
C. Criteria for a major depressive, manic, or hypomanic episode have never been met.
D. The symptoms in Criterion A are not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified or unspecified schizophrenia spectrum and other psychotic disorder. E. 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., hyperthyroidism).
F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: With anxious distress
Substance/Medication-Induced Bipolar and Related Disorder

Criteria:
A. A prominent and persistent disturbance in mood that predominates in the clinical picture and is characterized by elevated, expansive, or irritable mood, with or without depressed mood, or markedly diminished interest or pleasure in all, or almost all, activities.

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 a bipolar or related disorder that is not substance/medication-induced. Such evidence of an independent bipolar or related disorder could include the following:
   The symptoms precede the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence suggesting the existence of an independent non-substance/medication-induced bipolar and related disorder (e.g., a history of recurrent non-substance/medication-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Substance/Medication-Induced Bipolar and Related Disorder Due to Another Medical Condition

Criteria:
A. A prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy that predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or necessitates hospitalization to prevent harm to self or others, or there are psychotic features.

Specify if:
(F06.33) With manic features: Full criteria are not met for a manic or hypomanic episode.
(F06.33) With manic- or hypomanic-like episode: Full criteria are met except Criterion D for a manic episode or except Criterion F for a hypomanic episode.
(F06.34) With mixed features: Symptoms of depression are also present but do not predominate in the clinical picture.

Coding note: Include the name of the other medical condition in the name of the mental disorder (e.g., F06.33 bipolar disorder due to hyperthyroidism, with manic features). The other medical condition should also be coded and listed separately immediately before the bipolar and related disorder due to the medical condition (e.g., E05.90 hyperthyroidism; F06.33 bipolar disorder due to hyperthyroidism, with manic features).
OtherSpecifiedBipolarandRelatedDisorder
(F31.89)

This category applies to presentations in which symptoms characteristic of a bipolar 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 bipolar and related disorders diagnostic class. The other specified bipolar and 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 bipolar and related disorder. This is done by recording “other specified bipolar and related disorder” followed by the specific reason (e.g., “short-duration cyclothymia”).

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

1. Short-duration hypomanic episodes (2-3 days) and major depressive episodes: A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced two or more episodes of short-duration hypomania that meet the full symptomatic criteria for a hypomanic episode but that only last for 2-3 days. The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.
Other Specified Bipolar and Related Disorder (F31.89)

1. Hypomanic episodes with insufficient symptoms and major depressive episodes: A lifetime history of one or more major depressive episodes in individuals whose presentation has never met full criteria for a manic or hypomanic episode but who have experienced one or more episodes of hypomania that do not meet full symptomatic criteria (i.e., at least 4 consecutive days of elevated mood and one or two of the other symptoms of a hypomanic episode, or irritable mood and two or three of the other symptoms of a hypomanic episode). The episodes of hypomanic symptoms do not overlap in time with the major depressive episodes, so the disturbance does not meet criteria for major depressive episode, with mixed features.

2. Hypomanic episode without prior major depressive episode: One or more hypomanic episodes in an individual whose presentation has never met full criteria for a major depressive episode or a manic episode. If this occurs in an individual with an established diagnosis of persistent depressive disorder (dysthymia), both diagnoses can be concurrently applied during the periods when the full criteria for a hypomanic episode are met.
Unspecified Bipolar and Related Disorder (F31.9)

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

**Specify if:**

**With anxious distress:** The presence of at least two of the following symptoms during the majority of days of the current or most recent episode of mania, hypomania, or depression:

1. Feeling keyed up or tense.
2. Feeling unusually restless.
3. Difficulty concentrating because of worry.
4. Fear that something awful may happen.
5. Feeling that the individual might lose control of himself or herself.
Unspecified Bipolar and Related Disorder (F31.9)

**Specify current severity:**
Mild: Two symptoms.
Moderate: Three symptoms.
Moderate-severe: Four or five symptoms.
Severe: Four or five symptoms with motor agitation.

**Note:** Anxious distress has been noted as a prominent feature of both bipolar and major depressive disorder in both primary care and specialty mental health settings. High levels of anxiety have been associated with higher suicide risk, longer duration of illness, and greater likelihood of treatment nonresponse. As a result, it is clinically useful to specify accurately the presence and severity levels of anxious distress for treatment planning and monitoring of response to treatment.
Unspecified Bipolar and Related Disorder (F31.9)

**With mixed features:** The mixed features specifier can apply to the current manic, hypomanic, or depressive episode in bipolar I or bipolar II disorder:

**Manic or hypomanic episode, with mixed features:**

A. Full criteria are met for a manic episode or hypomanic episode, and at least three of the following symptoms are present during the majority of days of the current or most recent episode of mania or hypomania:

1. Prominent dysphoria or depressed mood as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).
2. Diminished interest or pleasure in all, or almost all, activities (as indicated by either subjective account or observation made by others).
3. Psychomotor retardation nearly every day (observable by others; not merely subjective feelings of being slowed down).
4. Fatigue or loss of energy.
5. Feelings of worthlessness or excessive or inappropriate guilt (not merely self-reproach or guilt about being sick).
6. 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.
Unspecified Bipolar and Related Disorder (F31.9)

B. Mixed symptoms are observable by others and represent a change from the person’s usual behavior.
C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features, due to the marked impairment and clinical severity of full mania.
D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, other treatment).
Unspecified Bipolar and Related Disorder (F31.9)

Depressive episode, with mixed features:
A. Full criteria are met for a major depressive episode, and at least three of the following manic/hypomaniac symptoms are present during the majority of days of the current or most recent episode of depression:
   1. Elevated, expansive mood.
   2. Inflated self-esteem or grandiosity.
   3. More talkative than usual or pressure to keep talking.
   4. Flight of ideas or subjective experience that thoughts are racing.
   5. Increase in energy or goal-directed activity (either socially, at work or school, or sexually).
   6. Increased or excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
   7. Decreased need for sleep (feeling rested despite sleeping less than usual; to be contrasted with insomnia).
Unspecified Bipolar and Related Disorder (F31.9)

B. Mixed symptoms are observable by others and represent a change from the person’s usual behavior.

C. For individuals whose symptoms meet full episode criteria for both mania and depression simultaneously, the diagnosis should be manic episode, with mixed features.

D. The mixed symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment). Note: Mixed features associated with a major depressive episode have been found to be a significant risk factor for the development of bipolar I or bipolar II disorder. As a result, it is clinically useful to note the presence of this specifier for treatment planning and monitoring of response to treatment.
Unspecified Bipolar and Related Disorder (F31.9)

**With rapid cycling** (can be applied to bipolar I or bipolar II disorder): Presence of at least four mood episodes in the previous 12 months that meet the criteria for manic, hypomanic, or major depressive episode.

**Note:** Episodes are demarcated by either partial or full remissions of at least 2 months or a switch to an episode of the opposite polarity (e.g., major depressive episode to manic episode).

**Note:** The essential feature of a rapid-cycling bipolar disorder is the occurrence of at least four mood episodes during the previous 12 months. These episodes can occur in any combination and order. The episodes must meet both the duration and symptom number criteria for a major depressive, manic, or hypomanic episode and must be demarcated by either a period of full remission or a switch to an episode of the opposite polarity. Manic and hypomanic episodes are counted as being on the same pole. Except for the fact that they occur more frequently, the episodes that occur in a rapid-cycling pattern are no different from those that occur in a non-rapid-cycling pattern. Mood episodes that count toward defining a rapid-cycling pattern exclude those episodes directly caused by a substance (e.g., cocaine, corticosteroids) or another medical condition.
Unspecified Bipolar and Related Disorder (F31.9)

With melancholic features:
A. One of the following is present during the most severe period of the current episode;
   1. Loss of pleasure in all, or almost all, activities.
   2. Lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens).
B. Three (or more) of the following:
   1. A distinct quality of depressed mood characterized by profound despondency, despair, and/or moroseness or by so-called empty mood.
   2. Depression that is regularly worse in the morning.
   3. Early-morning awakening (i.e., at least 2 hours before usual awakening).
   4. Marked psychomotor agitation or retardation.
   5. Significant anorexia or weight loss.
   6. Excessive or inappropriate guilt.
Unspecified Bipolar and Related Disorder (F31.9)

**Note**: The specifier “with melancholic features” is applied if these features are present at the most severe stage of the episode. There is a near-complete absence of the capacity for pleasure, not merely a diminution. A guideline for evaluating the lack of reactivity of mood is that even highly desired events are not associated with marked brightening of mood. Either mood does not brighten at all, or it brightens only partially (e.g., up to 20%-40% of normal for only minutes at a time). The “distinct quality” of mood that is characteristic of the “with melancholic features” specifier is experienced as qualitatively different from that during a nonmelancholic depressive episode. A depressed mood that is described as merely more severe, longer lasting, or present without a reason is not considered distinct in quality. Psychomotor changes are nearly always present and are observable by others. Melancholic features exhibit only a modest tendency to repeat across episodes in the same individual. They are more frequent in inpatients, as opposed to outpatients; are less likely to occur in milder than in more severe major depressive episodes; and are more likely to occur in those with psychotic features.
Unspecified Bipolar and Related Disorder (F31.9)

With atypical features: This specifier can be applied when these features predominate during the majority of days of the current or most recent major depressive episode.

A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events).

B. Two (or more) of the following features:
   1. Significant weight gain or increase in appetite.
   2. Hypersomnia.
   3. Leaden paralysis (i.e., heavy, leaden feelings in arms or legs).
   4. A long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.

C. Criteria are not met for “with melancholic features” or “with catatonia” during the same episode.
Unspecified Bipolar and Related Disorder (F31.9)

**Note:** “Atypical depression” has historical significance (i.e., atypical in contradistinction to the more classical agitated, “endogenous” presentations of depression that were the norm when depression was rarely diagnosed in outpatients and almost never in adolescents or younger adults) and today does not connote an uncommon or unusual clinical presentation as the term might imply. Mood reactivity is the capacity to be cheered up when presented with positive events (e.g., a visit from children, compliments from others). Mood may become euthymic (not sad) even for extended periods of time if the external circumstances remain favorable. Increased appetite may be manifested by an obvious increase in food intake or by weight gain. Hypersomnia may include either an extended period of nighttime sleep or daytime napping that totals at least 10 hours of sleep per day (or at least 2 hours more than when not depressed). Leaden paralysis is defined as feeling heavy, leaden, or weighted down, usually in the arms or legs. This sensation is generally present for at least an hour a day but often lasts for many hours at a time. Unlike the other atypical features, pathological sensitivity to perceived interpersonal rejection is a trait that has an early onset and persists throughout most of adult life. Rejection sensitivity occurs both when the person is and is not depressed, though it may be exacerbated during depressive periods. With psychotic features: Delusions or hallucinations are present at any time in the episode. If psychotic features are present, specify if mood-congruent or mood-incongruent: With mood-congruent psychotic features: During manic episodes, the content of all delusions and hallucinations is consistent with the typical manic themes of grandiosity, invulnerability, etc., but may also include themes of suspiciousness or paranoia, especially with respect to others’ doubts about the individual’s capacities, accomplishments, and so forth. With mood-incongruent psychotic features: The content of delusions and hallucinations is inconsistent with the episode polarity themes as described above, or the content is a mixture of mood-incongruent and mood-congruent themes.

**With catatonia:** This specifier can apply to an episode of mania or depression if catatonic features are present during most of the episode. See criteria for catatonia associated with a mental disorder in the chapter “Schizophrenia Spectrum and Other Psychotic Disorders.”
Unspecified Bipolar and Related Disorder (F31.9)

With peripartum onset: This specifier can be applied to the current or, if the full criteria are not currently met for a mood episode, most recent episode of mania, hypomania, or major depression in bipolar I or bipolar II disorder if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery. Note: Mood episodes can have their onset either during pregnancy or postpartum. Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery. Fifty percent of “postpartum” major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the “baby blues,” increase the risk for a postpartum major depressive episode.

Peripartum-onset mood episodes can present either with or without psychotic features. Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed, but psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations. Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1,000 deliveries and may be more common in primiparous women. The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of a depressive or bipolar disorder (especially bipolar I disorder) and those with a family history of bipolar disorders. Once a woman has had a postpartum episode with psychotic features, the risk of recurrence with each subsequent delivery is between 30% and 50%.

Postpartum episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention. The postpartum period is unique with respect to the degree of neuroendocrine alterations and psychosocial adjustments, the potential impact of breast-feeding on treatment planning, and the long-term implications of a history of postpartum mood disorder on subsequent family planning.
Unspecified Bipolar and Related Disorder (F31.9)

**With seasonal pattern:** This specifier applies to the lifetime pattern of mood episodes. The essential feature is a regular seasonal pattern of at least one type of episode (i.e., mania, hypomania, or depression). The other types of episodes may not follow this pattern. For example, an individual may have seasonal manias, but his or her depressions do not regularly occur at a specific time of year.

A. There has been a regular temporal relationship between the onset of manic, hypomanic, or major depressive episodes and a particular time of the year (e.g., in the fall or winter) in bipolar I or bipolar II disorder. Note: Do not include cases in which there is an obvious effect of seasonally related psychosocial stressors (e.g., regularly being unemployed every winter).

B. Full remissions (or a change from major depression to mania or hypomania or vice versa) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

C. In the last 2 years, the individual’s manic, hypomanic, or major depressive episodes have demonstrated a temporal seasonal relationship, as defined above, and no non-seasonal episodes of that polarity have occurred during that 2-year period.

D. Seasonal manias, hypomanias, or depressions (as described above) substantially outnumber any nonseasonal manias, hypomanias, or depressions that may have occurred over the individual’s lifetime.

**Note:** This specifier can be applied to the pattern of major depressive episodes in bipolar I disorder, bipolar II disorder, or major depressive disorder, recurrent. The essential feature is the onset and remission of major depressive episodes at characteristic times of the year. In most cases, the episodes begin in fall or winter and remit in spring. Less commonly, there may be recurrent summer depressive episodes. This pattern of onset and remission of episodes must have occurred during at least a 2-year period, without any nonseasonal episodes occurring during this period. In addition, the seasonal depressive episodes must substantially outnumber any nonseasonal depressive episodes over the individual’s lifetime.
Unspecified Bipolar and Related Disorder (F31.9)

This specifier does not apply to those situations in which the pattern is better explained by seasonally linked psychosocial stressors (e.g., seasonal unemployment or school schedule). Major depressive episodes that occur in a seasonal pattern are often characterized by prominent energy, hypersomnia, overeating, weight gain, and a craving for carbohydrates. It is unclear whether a seasonal pattern is more likely in recurrent major depressive disorder or in bipolar disorders. However, within the bipolar disorders group, a seasonal pattern appears to be more likely in bipolar II disorder than in bipolar I disorder. In some individuals, the onset of manic or hypomanic episodes may also be linked to a particular season. The prevalence of winter-type seasonal pattern appears to vary with latitude, age, and sex. Prevalence increases with higher latitudes. Age is also a strong predictor of seasonality, 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.
Bipolar Disorder versus Major Depression
Bipolar Disorder versus Major Depression

• History of manic episode

If a client has ever experienced a full manic episode, then the correct diagnosis would be Bipolar I Disorder even if the client currently presents with depression only.
Bipolar Disorder versus Thyroid Disease
Bipolar Disorders versus Thyroid Disease

• Neurochemical versus endocrinological versus both

There is a high rate of overlap between thyroid disorder and bipolar and a complex relationship and not yet fully understood relationship between the two

Lithium may interfere with thyroid functioning and predispose a client towards Hashimoto

Autoimmune thyroiditis may be related to bipolar disorder

Thyroid hormone is sometimes given as part of the treatment for bipolar disorder
Bipolar Disorders versus Thyroid Disease

Every person suspected of bipolar disorder should be referred to an endocrinologist due to the degree of overlap between these two disorders.