World Health Organization

Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders

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Introduction

The Eleventh Revision of the World Health Organization's International Classification of Diseases (ICD-11) was approved by the Seventy-second World Health Assembly, comprising the health ministers of all World Health Organization (WHO) Member States, on 25 May 2019 *(1)*. ICD-11 represents the first major, comprehensive revision of the ICD in nearly 30 years, and incorporates major advances in scientific evidence, best clinical practices and health information systems *(2)*. The development and maintenance of international classification systems for health and the standardization of diagnostic procedures are core constitutional functions of WHO *(3)*. By international treaty, WHO's 194 Member States agree to use the ICD as the standard for the reporting of health information to WHO. The ICD is therefore the fundamental global framework for monitoring mortality and morbidity, epidemics and other threats to public health, and disease burden. Reporting of health statistics to WHO based on the new system began on 1 January 2022 *(4)*.

Member States also use the ICD for other important purposes related to health services – for example, to facilitate access to appropriate health care, as a basis for developing clinical guidelines and standards of practice, and to facilitate research into more effective prevention and treatment strategies. Moreover, the governments of Member States use the ICD as a part of the framework for defining their obligations to provide free or subsidized health-care services to their populations *(5)*. That is, the diagnosis of a particular health condition typically confers eligibility to receive a specified range of health services. The implementation of the ICD in clinical systems is therefore extremely important because of the way it drives services, costs and outcomes.

This volume, *Clinical descriptions and diagnostic requirements for ICD-11 mental, behavioural and neurodevelopmental disorders* (CDDR), is the culmination of over a decade of collaborative work that took place within the context of the overall development of ICD-11 *(2)*. The development of the ICD-11 CDDR was led by the WHO Department of Mental Health and Substance Use, and constitutes the most broadly international, multilingual, multidisciplinary and participative revision process ever implemented for a classification of mental disorders *(6)*. The CDDR were planned, developed and field tested with the intent of providing mental health professionals, other health professionals, trainees and students with a comprehensive clinically useful guide to implementation of the ICD-11 classification of mental, behavioural and neurodevelopmental disorders. The CDDR are meant to support the accurate and reliable identification of mental health problems as they present in people seeking care in different settings worldwide, based on the best available evidence. Timely and accurate diagnosis of mental, behavioural and neurodevelopmental disorders can reduce the enormous disease burden associated with these conditions *(7)*, thereby advancing WHO's objective of "the attainment by all peoples of the highest possible level of health" *(3, p. 2)*.

The CDDR are an integral part of ICD-11, but they are distinct from the version used by Member States for statistical reporting of health information, which is referred to as the linearization for mortality and morbidity statistics (MMS) *(8)*. The MMS contain brief descriptions (or definitions) that are meant to be used for statistical and health information purposes for most categories in ICD-11, including all categories in the mental, behavioural and neurodevelopmental disorders chapter. In contrast, the CDDR, which have been developed specifically for the ICD-11 mental, behavioural and neurodevelopmental disorders chapter, provide substantially more detailed information needed by mental health and other health professionals to understand and apply this part of the classification in their work with patients.

A brief history of the CDDR

ICD-6 *(9)* was the first version of the classification published by WHO, the first to contain a classification of morbidity as well as mortality, and the first to include a classification of mental disorders. In both ICD-6 and ICD-7 *(10)*, the only information provided for mental disorders was the code number and name for each diagnostic category, along with inclusion terms, which specified some of the range of diagnostic concepts meant to be encompassed by the category. Starting with ICD-8 *(11)*, the WHO Department of Mental Health and Substance Use began to provide additional information to assist with clinical implementation. In 1974, the Department published a glossary of mental disorder terms and additional guidance related to the classification of mental disorders *(12)*, indicating that "unless some attempt is made to encourage uniformity of usage of descriptive and diagnostic terms, very little meaning can be attributed to the diagnostic side of statistics of mental illness based on the ICD and in many other ways communication between psychiatrists will become increasingly difficult" *(12, p. 12)*. Subsequently, brief definitions were also included in the main, statistical version of the classification for all categories in the mental disorders chapter in ICD-9 *(13)* and ICD-10 *(14)*. (This innovation in the classification of mental disorders in ICD-9 and ICD-10 has now been applied across the entire ICD-11 so that the MMS contain brief descriptions for most categories in the classification.) However, according to the WHO Department of Mental Health and Substance Use, these brief definitions were not recommended for use by mental health professionals but rather were intended for use in health statistics and in the coding of medical records and death certificates *(15)*.

In 1992, the Department published a volume entitled *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* (CDDG) *(15)* concurrently with the publication of the statistical version of ICD-10. The CDDG was "intended for general clinical, educational, and service use" *(15, p. 1)*. For each disorder, a description of the main clinical and associated features was provided, followed by more operationalized diagnostic guidelines that were designed to assist mental health clinicians in making a valid diagnosis.

The CDDR for ICD-11 represent an important advance in providing comprehensive practical guidance on diagnosing mental disorders. A major improvement in the ICD-11 CDDR compared to the ICD-10 CDDG is the consistency of structure and information across major categories, based on reviews of the available evidence *(16)*. The development of the CDDR has been guided by the principles of clinical utility and global applicability. The information included is intended to be useful to health professionals in making diagnostic judgements about individual patients, including the features they can expect to see in all cases of a given disorder and how to differentiate disorders from non-pathological expressions of human experience and from other disorders including medical conditions. The CDDR describe additional clinical features that may be present in some cases of a given disorder and provide key information that can assist in evaluating diagnoses across cultures, genders and the lifespan. More information about the specific contents and approach of the CDDR is provided in the next section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings. The reliability, clinical utility and global applicability of the CDDR have been confirmed through a comprehensive programme of developmental and evaluative field studies *(6,17–19)* that involved thousands of clinicians in all global regions. This research programme is described in more detail later in this chapter.

Intended users of the CDDR

The CDDR are designed to be used by mental health professionals who are authorized by training, scope of practice and applicable statute to provide diagnostic evaluations of people with mental disorders (e.g. psychiatrists, psychologists in some countries). They are also intended to

be useful to non-specialist health professionals (e.g. primary care physicians, nurses), who in many countries provide a substantial proportion of total mental health services. They will also be useful for other professionals in clinical and non-clinical roles who need to understand the nature and symptoms of these disorders even if they do not personally diagnose them. Finally, the CDDR are intended to provide students and trainees in variety of mental health and other health fields with comprehensive guidance and information to support their development as competent diagnosticians or interdisciplinary team members.

It is important to note that the organization of ICD-11 into chapters is not intended to reflect the scope of practice of specific medical specialties or clinical professions. For example, mental, behavioural and neurodevelopmental disorders and diseases of the nervous system are in separate chapters, but WHO does not intend this as a statement that psychiatrists should not be allowed to assess and treat headache disorders or that neuropsychologists should not be permitted to evaluate which disease process may be causing a particular case of dementia given the pattern of symptoms. Similarly, certain mental disorders (e.g. neurocognitive disorders such as dementia or delirium, or dissociative disorders such as dissociative neurological symptom disorder or dissociative amnesia), frequently come to the attention of a variety of health professionals (e.g. primary care physicians, neurologists) who may be equipped to evaluate and diagnose them using the CDDR as a guide.

Health-care professionals using the CDDR to make diagnoses should be qualified to do so by their clinical training and experience, and are expected to have the necessary clinical expertise and understanding of mental disorders to identify symptoms and to distinguish disorders from normal variation, from one another, and from transient responses to stress or environmental circumstances. The CDDR are written to allow for the exercise of clinical judgement, and it is the diagnosing health professional who is responsible for developing a diagnostic formulation appropriate for an individual patient, considering the patient's individual, social and cultural context as well as the characteristics of the health system. It is equally important to note that diagnostic classification is only *a part* of patient assessment. The CDDR are not a guide to patient care, nor a comprehensive textbook of psychiatry, nor a manual of how to conduct clinical assessments and differential diagnoses. The focus of the CDDR is on the classification of *disorders* and not the assessment and treatment of *people*, who are frequently characterized by multiple disorders and diverse needs *(5)*.

Development of the MMS and the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders

As noted above, the WHO Department of Mental Health and Substance Use led the development of the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders, including both the MMS and the CDDR. Over the course of more than a decade, the Department coordinated an intensive, systematic, international process that involved a wide range of key stakeholder groups including scientific and public health experts, clinicians, representatives of WHO Member States, scientific and professional societies, service users and their carers, and other nongovernmental organizations. All expert contributors to this document were asked to complete a WHO Declaration of Interests (DoI) form prior to their contribution. Once received, the WHO Secretariat reviewed the DoI forms and evaluated whether there were any conflicts of interest and, if so, whether these required a management plan. Prior to the finalization of this document, all contributors were asked to complete another DOI form. No conflicts of interest requiring a management plan were identified.

Formation of the ICD-11 International Advisory Group

In 2007, the WHO Department of Mental Health and Substance Use appointed the International Advisory Group for the Revision of ICD-10 Mental and Behavioural Disorders *(5)*, comprising scientific experts from all WHO regions and representatives from relevant international scientific societies. This Advisory Group was tasked with scientific oversight for the entire revision process. Its specific functions were to advise WHO on the key guiding principles and goals of the revision, the steps involved in the revision, and identification of other groups of relevant consultants and stakeholders required to develop the classification of mental disorders and other relevant parts of ICD-11; and to facilitate the implementation of global field studies to assess and improve the revisions to ICD-11 and the CDDR. The Advisory Group also functioned as one of approximately 30 topic advisory groups for the overall development of ICD-11, each focusing on a different area or cross-cutting theme (e.g. gastroenterology, ophthalmology, quality and safety) and represented on the Revision Steering Committee – working with the WHO Classifications and Terminology and Data Standards Team responsible for coordinating the overall effort.

Development of the CDDR by ICD-11 working groups

The International Advisory Group advised the WHO Department of Mental Health and Substance Use on the appointment of more than a dozen working groups tasked with reviewing the relevant evidence and making proposals for changes to the structure and content of the ICD-10 classification of mental, behavioural and neurodevelopmental disorders. Most of the working groups were established in relation to a particular subset of mental disorders (e.g. psychotic disorders, mood and anxiety disorders, personality disorders). Others were appointed to make proposals regarding how cross-cutting themes (e.g. presentations in children and adolescents, presentations in older adults, cultural factors) would be handled in the CDDR. Members of the working groups were expert multidisciplinary mental health professionals with relevant scientific and/or clinical expertise. The working groups were constituted such that experts from all WHO regions were included, with substantial representation from low- and middle-income countries.

The working groups' charge included reviewing the extant body of basic science, clinical and public health research relevant to their area of responsibility for use as a basis for their recommendations for revisions to the classification of mental disorders in ICD-10. The working groups used these reviews to recommend changes to enhance the validity of ICD-11 (e.g. addition or deletion of categories, changes in thresholds or diagnostic requirements). They also reviewed available evidence related to the clinical utility of proposed changes, such as whether the revised diagnostic descriptions would enhance the identification of individuals who need mental health services or their usefulness in treatment and management decisions in a range of global health-care settings, particularly in low- and middle-income countries. Working groups proposed specific changes to the structure of the classification of mental disorders in ICD-11; what categories and specifiers were included; and the MMS brief descriptions and the CDDR for the area under their purview. They were asked to provide the rationale, evidence base and expected impact on clinical utility of any proposed change via a structured, documented process *(16)*.

Working groups were instructed to emphasize considerations of clinical utility and global applicability in developing their recommendations. Clinical utility is important because health classifications represent the interface between health encounters and health information. A system that does not provide clinically useful information at the level of the health encounter will not be faithfully implemented by clinicians. In that case, data aggregated from health encounters will not be optimal and perhaps not even valid, affecting the usefulness and validity of summary health encounter data used for decision-making at the health system, national and global level. The WHO Department of Mental Health and Substance Use operationalized the clinical utility

of a category in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders as depending on:

- its value in communicating (e.g. among practitioners, patients, families, administrators);
- its implementation characteristics in clinical practice, including its goodness of fit (i.e. accuracy of description), its ease of use and the time required to use it (i.e. feasibility);
- and its usefulness in selecting interventions and in making clinical management decisions.

Global applicability was addressed via the diverse global membership of the working groups and by the international nature of the field studies implemented as part of the development of the CDDR, and by specific attention to culture as a part of the CDDR (see the sections on public review and field testing and on cultural factors below).

In order to generate relatively uniform information and a consistent structure across groupings and categories of the CDDR (see the next section on using the ICD-11 classification of mental, behavioural and neurodevelopmental disorders in clinical settings), working groups collated diagnostic information using a standardized template (referred to as a "content form"), with relevant references. This information served as source material for the development of the CDDR, with the final editorial responsibility vested in the WHO Department of Mental Health and Substance Use. The brief descriptions in the MMS and the more detailed essential features in the CDDR were developed together in order to be fully compatible, though designed for different purposes. The MMS brief descriptions are typically summaries of the essential features for the corresponding entity in the CDDR, although these brief descriptions alone do not provide sufficient information for implementation in clinical settings.

Public review and field testing

Proposals developed by working groups were described in the scientific literature *(e.g. 20–26)*, made available for public review *(27)*, and tested via a systematic programme of global field studies (see the section on field studies below). Scientific oversight for the field studies was provided by the ICD-11 Field Studies Coordination Group (FSCG) *(28)*, comprising global leaders in clinical care, scientific research and public health representing all WHO regions, with substantial representation from low- and middle-income countries. FSCG members not only lent their technical expertise to the design, analysis and interpretation of the field studies but also served as essential facilitators by successfully engaging global clinicians to participate in ICD-11 field studies around the world. Many of them directed international field study centres, which conducted field studies in routine clinical settings with real patients. The FSCG and relevant working groups were also involved in proposing changes to the CDDR based on the results of the field studies *(17)*.

WHO's comprehensive programme of field testing to assess the reliability, clinical utility and global applicability of the proposed CDDR was a major area of innovation, employing novel study designs and new methodologies for collecting information. Global participation was a defining characteristic of the ICD-11 CDDR field studies, which engaged multidisciplinary clinicians working in diverse contexts across the world, and were conducted in multiple languages. A key strength of the research programme was that studies were conducted within a time frame that allowed the results to be used as a basis for further revision of the CDDR prior to publication.

Early in the revision process, two major international, multilingual surveys were conducted – one of psychiatrists, conducted in collaboration with the World Psychiatric Association *(29)* and the other of psychologists, conducted in collaboration with the International Union of Psychological Science *(30)*. These surveys focused on participants' use of diagnostic classification systems in clinical practice, and the desirable characteristics of a classification of mental disorders. The professionals overwhelmingly preferred more flexible guidance to allow for cultural variation

and clinical judgement compared to a strict criteria-based approach, and were receptive to a system incorporating a dimensional component. Respondents described a number of categories as having poor clinical utility in practice, while others were recommended for addition or deletion *(31,32)*. These data were used in the initial decisions about the content of the CDDR and in the development of diagnostic guidance by working groups.

In order to provide data to assist in developing an organizational structure that would be more clinically useful, two formative field studies were conducted to examine the conceptualizations held by mental health professionals around the world regarding the structure of mental disorders and the relationships among them *(33,34)*. These data showed a high degree of similarity across countries, languages and regions, regardless of the classification system participants used in clinical practice, and informed decisions about the structure of the classification.

The proposed CDDR material was then tested in two main sets of evaluative field studies: case-controlled (internet-based) and ecological implementation (clinic-based) field studies. The case-controlled studies assessed the clinical utility of the proposed diagnostic material; most compared how global clinicians applied the proposed ICD-11 material versus the ICD-10 diagnostic guidelines for a given diagnostic area in terms of accuracy and consistency of clinicians' diagnostic formulations, using a scientifically rigorous vignette-based methodology *(17,35)*. Other studies examined scaling for diagnostic specifiers *(36)* and how clinicians actually used classifications in their clinical practice *(37)*, including how they combined multiple dimensions in making a categorical diagnosis *(38)*.

Case-controlled studies were conducted in between three and six languages – Chinese, English, French, Japanese, Spanish and Russian – per study, with participation from thousands of clinicians from across the globe who were members of WHO's Global Clinical Practice Network. The Network's field studies have assessed a wide range of disorder groupings *(e.g. 39–45)*. Two internet-based studies comparing ICD-11 to ICD-10 were also conducted in German *(46,47)*. Overall, these studies have demonstrated incrementally superior – or in some cases equivalent – performance of the ICD-11 CDDR compared to the ICD-10 CDDG in the accuracy of diagnoses assigned to case vignettes by participating clinicians, as well as improvements in ratings of clinical utility. When a clinician's diagnoses did not follow the expected pattern, the study methodology allowed for examination of which specific features of the diagnostic requirements accounted for underperformance, which in turn permitted modifications to the CDDR to address points of ambiguity or misunderstanding *(e.g. 39,44)*. These studies also included analyses of results by region and language to identify potential difficulties in global or cultural applicability, as well as problems in translation. In addition to refining the CDDR, data from these studies have provided useful information for the development of training programmes on the new ICD-11 diagnostic material. For example, the German study examining performance on a coding task suggested a substantial need for training initiatives to support the use of ICD-11 by professional coders *(47)*.

Two major ecological implementation (clinic-based) field studies were conducted. The first tested the proposed CDDR diagnostic material when applied by practising clinicians to adult patients receiving care in the types of clinical settings in which the CDDR will be implemented *(18,19)*. The study was conducted in 14 countries – Brazil, Canada, China, Egypt, India, Italy, Japan, Lebanon, Mexico, Nigeria, the Russian Federation, South Africa, Spain and Tunisia – via a network of international field study centres. The study assessed the reliability and clinical utility of the CDDR for disorders that account for the highest percentage of global disease burden and use of mental health services in clinical settings among adults: schizophrenia and other psychotic disorders, mood disorders, anxiety and fear-related disorders, and disorders specifically associated with stress. A joint-rater reliability methodology, in which two clinicians were present during the patient interview but reported their diagnostic formulation and clinical utility ratings

independently, was employed in order to isolate the effects of the CDDR from other sources of variance in diagnosis (e.g. changes over time, inconstancy in reporting). Importantly, the level of training on the ICD-11 CDDR received by participating clinicians was similar to what might be expected in routine clinical setting during ICD-11 implementation. Clinicians were given no instructions on how to conduct their diagnostic interviews other than to assess the areas that were required as part of the study protocol. Overall, intraclass kappa coefficients (a measure of reliability between raters) for diagnoses weighted by site and study prevalence ranged from 0.45 (dysthymic disorder) to 0.88 (social anxiety disorder). The reliability of the ICD-11 diagnostic requirements was superior to that previously reported for equivalent ICD-10 guidelines *(18)*. Clinician ratings of the clinical utility of the ICD-11 CDDR were very positive overall. The CDDR were perceived as easy to use, accurately reflecting patients' presentations (i.e. goodness of fit), clear and understandable, and no more time-consuming than the clinicians' standard practice *(19)*.

A separate study of common child and adolescent diagnoses was conducted in four countries – China, India, Japan and Mexico – with children and adolescents from 6 to 18 years of age *(48)*. The study focused on attention deficit hyperactivity disorder, disruptive behaviour and dissocial disorders, mood disorders, anxiety and fear-related disorders, and disorders specifically associated with stress, using a design that was analogous to the adult study. Kappa estimates indicated substantial agreement for most categories, with moderate agreement for generalized anxiety disorder and adjustment disorder. No differences were found between younger (6–11 years) and older (12–18 years) age groups, or between outpatient and inpatient samples. Clinical utility ratings for these diagnoses were positive and consistent across the domains assessed, although they were somewhat lower for adjustment disorder. Taken together, the results of the ecological implementation studies supported the implementation of the ICD-11 CDDR in clinical settings, and suggested that the results of the case-controlled studies were generalizable to clinical settings. Another clinic-based field study in three countries examining the novel behavioural indicators for the assessment of the severity of ICD-11 disorders of intellectual development found them to have good to excellent levels of inter-rater reliability, concurrent validity and clinical utility. This supported their use to assist in the accurate identification of individuals with disorders of intellectual development, particularly in settings where specialized assessment services are unavailable *(49)*.

A separate field studies programme to test the section of the ICD-11 CDDR on disorders due to substance use and addictive behaviours involved field testing centres in 11 countries: Australia, Brazil, China, France, Indonesia, India, the Islamic Republic of Iran, Malaysia, Mexico, Switzerland and Thailand. The main aim of the studies was to explore the public health and clinical utility, feasibility and stability (comparability with ICD-10) of the proposed CDDR for disorders due to the use of psychoactive substances, as well as the newly designated subgrouping of disorders due to addictive behaviours (i.e. gambling disorder and gaming disorder). The mixed-methods approach used in these studies included key informant surveys and interviews, focus groups and consensus conferences at each study site. Across sites, more than 1000 health professionals participated in the survey, more than 200 participants were involved in 30 focus groups organized at the study sites, and 42 identified national experts in the field reviewed the draft CDDR.

Overall, this section of ICD-11 was judged to be major step forward compared to ICD-10 in terms of its utility for meeting clinical and public health, and its feasibility for implementation. There was broad support for major innovations in this area. For disorders due to substance use, this included the expansion of substance classes to reflect evolving patterns in global psychoactive substance use (e.g. synthetic cannabinoids, MDMA[1] or related drugs), the introduction of new categories to capture episodes of harmful substance use, and the inclusion of the concept of "harm to health of others" in the definition of harmful substance use *(25)*. There was also support for

1 3,4-methylenedioxy-methamfetamine, also known as "ecstasy".

integrating disorders due to addictive behaviour in the same overarching grouping as disorders due to substance use, and for the introduction of the new diagnostic category gaming disorder. At the same time, the field study results highlighted the overall increase in complexity of this part of ICD-11 and the need for training of health professionals in order to ensure a smooth transition. The field studies also yielded specific suggestions for better delineation of the boundaries among some diagnostic categories as well as better descriptions of new ones.

In addition, WHO commissioned a study *(50)* on the concordance among diagnoses for alcohol and cannabis use disorders based on ICD-11, ICD-10 and the Diagnostic and Statistical Manual of Mental Disorders, fourth and fifth editions (DSM-IV and DSM-5) *(51,52)*. The results of the study demonstrated high concordance among the populations identified by the ICD-11 diagnostic requirements compared to ICD-10 and DSM-IV. Concordance of between ICD-11 and DSM-5 was substantially lower, in large part due to low agreement between the diagnoses of harmful pattern of alcohol use and harmful pattern of cannabis use in ICD-11 and mild alcohol use disorder and mild cannabis use disorder in DSM-5.

Development of the CDDR also included the involvement of mental health service users and carers through two studies in 15 countries representing diverse clinical contexts in multiple global regions *(53,54)*. These studies constituted the first instance of a systematic research programme studying mental health service users' perspectives during the revision of a major diagnostic classification system. The studies employed participatory research methodologies to systematically collate service user perspectives on key CDDR diagnoses that contribute to high disease burden, including schizophrenia, depressive episode, bipolar type I disorder, generalized anxiety disorder and personality disorder. Findings from these studies provided an understanding of how mental health service users respond to diagnostic content of the CDDR, and served as a basis for providing recommendations to WHO about potential enhancements of CDDR diagnostic material that may enhance its clinical utility (e.g. its usefulness in communicating with service users) and mitigating potential unintended negative consequences of the diagnostic material, including stigmatization of diagnosed individuals.

Coordination with the development of DSM-5

The development of ICD-11 overlapped with the development and publication of DSM-5 *(52)*. The Chair and Co-Chair of the DSM-5 Task Force regularly attended meetings of the Advisory Group in an effort to facilitate "harmonization" of the two classifications. This was most successful in terms of the way that mental disorders are divided into groupings and how those groupings are ordered in the two classifications (referred to as the "metastructure"). In this regard, ICD-11 and DSM-5 are quite similar to one another, though not identical, and substantially different from ICD-10 and DSM-IV. Most ICD-11 working groups included at least one member of the corresponding DSM-5 workgroup. ICD-11 working groups were asked to consider the clinical utility and global applicability of material being developed for DSM-5, with the goal of minimizing unintentional or arbitrary differences between the two systems. Intentional conceptual differences were permitted, however, and the working groups were asked to provide a justification for such differences where they were proposed. The differences between ICD-11 (both the MMS and the CDDR) and DSM-5 are therefore conscious and intentional *(16,55)*, and a number of such differences have stimulated valuable research that has enhanced our knowledge about psychopathology *(56)*.

Key approaches to classifying mental, behavioural and neurodevelopmental disorders

The definition of mental, behavioural and neurodevelopmental disorders

The ICD-11 chapter on mental, behavioural and neurodevelopmental disorders begins with the following definition:

Mental, behavioural and neurodevelopmental disorders are syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

The term "disorder" is used as a part of nearly all category titles in the chapter. Although "disorder" is not a precise term, as in ICD-10 its use is intended "to avoid even greater problems inherent in the use of terms such as 'disease'" *(15, p. 11)*, which implies greater certainty about etiology and pathophysiology than exists for most mental disorders. Although mental disorders are by definition syndromes, "syndrome" is a broader term with more variable usage. Its use in category titles in the classification of mental, behavioural and neurodevelopmental disorders is restricted to the grouping of secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere; these are conditions with more variable symptoms that are less specified in the CDDR, but are judged to be direct pathophysiological consequences of a medical condition. Other conditions referred to as syndromes that are mentioned in the CDDR are classified in other parts of ICD-11 (e.g. Tourette syndrome is included in the chapter on diseases of the nervous system).

Beyond the issue of terminology, the definition of mental, behavioural and neurodevelopmental disorders helps to delineate two boundaries. The first is the boundary between mental, behavioural and neurodevelopmental disorders and diseases and disorders classified in other chapters of ICD-11, and the second is the boundary between mental, behavioural and neurodevelopmental disorders and normality. Both of these boundaries represent key issues in diagnosis. The first part of the definition ("clinically significant disturbance in an individual's *cognition, emotional regulation or behaviour*") indicates that the essential features of the disorders included in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders invariably involve (but are not limited to) symptoms from these domains of mental and behavioural functioning. The presentation of disorders in other ICD-11 chapters (e.g. those on diseases of the nervous system and sleep-wake disorders) may include disturbances in these domains, but they are not common to all the disorders in those chapters.

The second part of the definition is intended to clarify that in order for a clinical presentation to be diagnosable as a mental, behavioural or neurodevelopmental disorder (as opposed to representing normal variation), the symptom must reflect a *dysfunction* in an underlying psychological, biological or developmental process. For example, the experiences of an individual who has recently been bereaved might include acute feelings of sadness and emptiness accompanied by disturbances in cognition, emotional regulation or behaviour. However, symptoms entirely attributable to grief are not in and of themselves indicative of an underlying dysfunction in a psychological, biological or developmental process. Normal bereavement is not considered to be a disorder, despite its potential negative impact on social and occupational functioning. Similarly, behaviour (e.g. political, religious, sexual) that deviates from the accepted standards of society is only considered to be symptomatic of a mental disorder if it is a manifestation of a dysfunction in a psychological, biological or developmental process.

The final part of the definition ("these disturbances are *usually* associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning") notes that distress in the individual and/or impairment in functioning is commonly a consequence of the symptoms, and for many mental disorders is an essential feature. At the same time, it is not always required (e.g. individuals experiencing a hypomanic episode in the context of bipolar type II disorder often do not experience distress about their condition, and by definition do not exhibit functional impairment), hence the use of "usually" in the definition.

Structure of the chapter on mental, behavioural and neurodevelopmental disorders

The organization of the ICD-10 chapter on mental and behavioural disorders had been dictated in part by the ICD-10 coding system itself. The first character of ICD-10 codes, which indicated the chapter, was alphabetical, thus allowing for up to 26 chapters. The second character, which indicated the diagnostic grouping within the chapter, was numerical, effectively limiting the number of possible diagnostic groupings within a chapter to 10. The use of alphanumeric characters throughout the ICD-11 coding system removes those artificial constraints. Consequently, there are 21 diagnostic groupings in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders. A few of the ICD-11 diagnostic groupings are completely parallel to ICD-10 groupings (e.g. disorders due to substance use, schizophrenia and other primary psychotic disorders, mood disorders). Most of the other ICD-10 diagnostic groupings were split into multiple ICD-11 groupings. For example, ICD-10 neurotic, stress-related and somatoform disorders was split into five ICD-11 diagnostic groupings: anxiety and fear-related disorders; obsessive-compulsive and related disorders; disorders specifically associated with stress; dissociative disorders; and bodily distress disorders.

In one case, three ICD-10 diagnostic groupings (mental retardation; disorders of psychological development; and behavioural and emotional disorders with onset usually occurring in childhood and adolescence) were combined into a single neurodevelopmental disorders grouping in ICD-11, although some of the disorders that were included in the behavioural and emotional disorders with onset usually occurring in childhood and adolescence grouping in ICD-10 were placed into other ICD-11 diagnostic groupings based on symptomatic presentations (e.g. conduct disorders were placed in the disruptive behaviours or dissocial disorders grouping in ICD-11). Disorders of intellectual development in ICD-11 have been reconceptualized from ICD-10 mental retardation such that they are assessed based on adaptive behaviour functioning in addition to intellectual functioning.

The elimination of ICD-10 diagnostic groupings explicitly linked to onset of the condition during childhood and adolescence is in part related to the decision to adopt a lifespan approach to the description of diagnostic categories in ICD-11. Each category contains a section on developmental presentations, which describes the manifestations of the disorder in early and middle childhood, adolescence and older adulthood, to the extent possible based on available evidence. The ICD-11 CDDR also include descriptions of adult presentations of most disorders described exclusively in terms of children in the ICD-10 CDDG (e.g. attention deficit hyperactivity disorder, separation anxiety disorder, conduct disorder, pica).

Four diagnostic subgroupings were moved out of the mental, behavioural and neurodevelopmental disorders chapter entirely and placed within other ICD-11 chapters: ICD-10 nonorganic sleep disorders were moved to the ICD-11 chapter on sleep-wake disorders, ICD-10 sexual dysfunctions not caused by organic disorder or disease and gender identity disorders were moved to the ICD-11 chapter on conditions related to sexual health, and ICD-10 tic disorders were moved to the ICD-11 chapter on diseases of the nervous system. The movement of sleep-wake disorders and sexual dysfunctions to new, separate chapters in no way indicates that these conditions are

not appropriately treated by mental health professionals. Rather, it reflects an effort to remove the artificial and scientifically and clinically inaccurate "mind–body split" embodied in the designation of "organic" and "nonorganic" forms of these disorders. The inclusion of ICD-11 gender incongruence in the chapter on conditions related to sexual health reflects the conclusion that these conditions are not appropriately viewed as mental disorders based on a series of international field studies indicating that distress and functional impairment in transgender people is predicted by experiences of stigmatization and victimization rather than being an intrinsic characteristic of being transgender *(57–59)*.

Categories and dimensions

ICD-10 was almost entirely categorical in nature (categories were either present or absent), with the only exceptions being severity-based subcategories for mental retardation (mild, moderate, severe, profound) and depressive episode (mild, moderate, severe). ICD-11 has moved beyond a strictly categorical approach, incorporating dimensional elements in two different ways. First, in addition to intellectual developmental disorder and depressive episode, bodily distress disorder, personality disorder and dementia are subcategorized based on severity (mild, moderate, severe). Second, a number of mental disorders allow for the indication of symptomatic manifestations that are intended to provide dimensional profiles that cut across different disorders in a particular grouping. These include symptomatic manifestations of primary psychotic disorders (positive symptoms, negative symptoms, depressive mood symptoms, manic mood symptoms, psychomotor symptoms, cognitive symptoms), which can be further coded as not present, mild, moderate or severe, and prominent personality trait domains in personality disorders (negative affectivity, detachment, asociality, disinhibition, anankastia). See the following section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings for specific examples of how these dimensional specifiers are coded.

Cultural factors

Because the CDDR will be employed around the world as a basis for diagnosis and treatment selection among people living in diverse social milieus and cultural contexts, a key priority in development of the diagnostic material was to consider and reflect the influence of culture. Cultural factors affect the diagnosis of mental, behavioural and neurodevelopmental disorders in complex and multifaceted ways. For example, culture can influence how disorders are conceptualized, experienced and expressed; what is considered normal or pathological; how functioning is affected; where and how people seek care; and the ways that patients and families participate in treatment. Attention to culture was also in line with the overall priority of the revision process to enhance the clinical utility and global applicability of the CDDR. Information that makes the diagnostic system more relevant and acceptable to clinicians and service users around the world can enhance the usefulness of the CDDR as tool for identifying those who require care and connecting them to services.

WHO appointed a Working Group on Cultural Considerations to develop material on culture for the CDDR. This Working Group conducted extensive consultations with experts from around the world, and systematically reviewed the literature on cultural influences on diagnosis and psychopathology for each diagnostic category, as well as relevant material on culture from ICD-10 and DSM-5. Information was also collated from materials produced by other ICD-11 working groups as part of their generation of proposed content for their respective diagnostic areas.

On this basis, the Working Group developed a section entitled "culture-related features" for diagnostic categories in the CDDR. The focus was on providing pragmatic, actionable material to assist clinicians in using the CDDR to evaluate patients in a culturally informed manner and reduce bias in clinical decision-making. This section is meant to be of practical use in the process

of engagement, diagnosis, evaluation and treatment selection, and addresses the following areas:

- cultural variation in prevalence and symptoms of disorders;
- information about social contexts and sociocultural mechanisms that may account for this variation; and
- descriptions of cultural concepts of distress (e.g. idioms, causal explanations) that are relevant to diagnosis and treatment decisions, prioritizing cultural variations that may be associated with national or ethnocultural background *(60,61)*.

The resulting guidance aims to assist the clinician in making informed decisions likely to foster more contextually applicable patient-centred care that is sensitive to the cultural and social milieu of the clinical encounter.

For example, the section on culture-related features of the CDDR for panic disorder indicates that the symptom presentation of panic attacks may vary across cultures, and describes several notable cultural concepts of distress that link panic, fear or anxiety to cultural attributions regarding specific social and environmental influences. Understanding these attributions can assist in differential diagnosis and can also clarify whether panic attacks should be considered expected or unexpected (as is required for a diagnosis of panic disorder) given the environmental circumstances.

The development of the CDDR incorporated cultural considerations in several other ways. First, global applicability of diagnostic material was identified early on as an overarching objective of the CDDR, and the development process was led and guided by experts and clinicians representing all major global areas. The Advisory Group, the FSCG and all working groups included members with diverse geographical and linguistic backgrounds, many of whom had direct experience working in low-resource contexts and within various cultures.

The design and implementation of ICD-11 field studies also adhered to the principle of enhancing the global and cultural applicability of the CDDR by engaging thousands of clinicians from around the world in a comprehensive research programme to assess the reliability, clinical utility and global applicability of the requirements. For example, the formative studies that helped to shape the architecture and linear structure of the CDDR involved clinicians from over 40 countries and were conducted in multiple languages. The evaluative case-controlled studies engaged clinicians in large-scale, multilingual studies related to major diagnostic areas of the CDDR. The clinicians who participated in the case-controlled studies were members of the Global Clinical Practice Network *(62)*, which now includes more than 18 000 mental health professionals from over 160 countries, and was established by WHO for the purposes of assisting in the development of ICD-11 by its members participating in internet-based field studies. Similarly, clinic-based field studies testing the implementation of the CDDR with real patients took place in over 25 study sites in 14 culturally, linguistically and geographically diverse countries. Hundreds of clinicians in these countries provided feedback directly on the CDDR to help enhance its reliability and utility in culturally diverse global settings.

Using the CDDR in research

In addition to the ICD-10 CDDG, the WHO Department of Mental Health and Substance Use published *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research* (DCR) *(63)* as a companion document. The DCR presented fully operationalized criteria for ICD-10 mental disorder entities, specifically intended for use in research. These criteria were designed to replace the "diagnostic guidelines" portion of the corresponding category in the CDDG, which tended to be more flexible and less fully operationalized. The core criteria-based approach taken in the DCR was therefore much more compatible with the approach of

DSM-IV *(51)*, although substantial differences between the two systems remained *(64)*. However, almost no research using the ICD-10 DCR appears to have been published.

The greater standardization and the provision of a broader and more systematic range of clinically relevant information in the ICD-11 CDDR compared to the ICD-10 CDDG *(16)* was designed to make the CDDR more useful in clinical decision-making, and therefore also in education and training. The extremely high ratings of the clinical utility of the CDDR, particularly in international clinic-based field studies with real patients *(19,48)* suggest that this objective was achieved. Moreover, the solid reliability results from the ICD-11 field studies *(18,48)* indicate that the CDDR would be satisfactory for use in certain kinds of research projects – for example, projects focused on individuals with particular diagnoses as these are assigned in health-care settings (e.g. patients diagnosed with recurrent depressive disorder receiving services at a particular facility).

However, in other types of research projects, in which obtaining reproducible and precise psychiatric diagnoses is more important, standardized diagnostic assessment procedures are necessary. This is meant to control variability inherent in diagnostic processes that rely on the interviewer's diagnostic interviewing skills (different interviewers may ask different questions to assess the same clinical phenomena) and clinical judgement (different interviewers may arrive at different diagnostic conclusions). For example, studies of the efficacy of treatments for particular disorders require consistency in diagnostic procedures to ensure that the population being studied has been assigned the diagnosis for which the treatment is intended according to consistent and explicit diagnostic rules to reduce random diagnostic heterogeneity. Similarly, epidemiological studies that utilize lay (i.e. not clinically trained) interviewers to apply the ICD-11 CDDR require pre-scripted questions and strict decision rules because they cannot rely on the clinical expertise of the interviewer to make judgements about which features are present. For these reasons, several WHO-sponsored diagnostic instruments are being developed to facilitate the application of the ICD-11 CDDR in particular research settings.

The Structured Clinical Interview for ICD-11 (SCII-11) is a semi-structured diagnostic interview that requires experience in clinical interviewing on the part of the interviewer. The SCII-11 is designed to be used in conjunction with the CDDR, and provides a standardized set of questions to assist researchers to elicit the information needed to conduct a differential diagnosis in the context of research studies. It will also be useful for training purposes and in clinical settings.

The development of the SCII-11 required extensive decisions about operationalizing the CDDR so that they can be more reliably applied in research settings. The SCII-11 operationalized the CDDR in two different ways: by substituting more precise diagnostic thresholds and by the choice of wording of corresponding interview questions. The CDDR intentionally avoid artificially precise duration and symptom cutoffs, allowing clinicians more flexibility for clinical judgement. The SCII-11 modifies some of the CDDR items, substituting more precise thresholds. For example, the ICD-11 CDDR for panic disorder define a panic attack as follows: "Panic attacks are discrete episodes of intense fear or apprehension also characterized by the rapid and concurrent onset of **several** characteristic symptoms. These symptoms may include, but are not limited to, the following…" The SCII-11 has modified this item, substituting the word "several" with "at least three". Similarly, the CDDR incorporate many broadly defined diagnostic constructs that could be assessed in different ways. Rather than relying on the interviewer to decide the best way to assess them, the SCII-11 operationalizes diagnostic constructs through the specificity and wording of corresponding interview questions. For example, the CDDR for schizophrenia require the presence of at least two items from a list of seven, most of the time for a period of 1 month, with one of the seven being "persistent delusions (e.g. grandiose delusions, delusions of reference, persecutory delusions)". Since there is no single question that can satisfactorily cover every type of delusion, the SCII-11 divides the assessment of delusions into separate questions corresponding to specific types of delusions (e.g. delusions of reference, persecutory delusions,

grandiose delusions, delusions of guilt, somatic delusions). Given that it is a semi-structured rather than a fully structured interview, the interviewing clinician also has the option of following up on particular responses or asking additional questions in order to assess the relevant phenomena fully. WHO plans to make available a list of the operational decisions implemented in the SCII-11 as a resource in the development of other instruments to encourage greater cross-instrument agreement.

In addition, WHO is developing a fully structured diagnostic interview to be used in epidemiological studies and in other situations in which the SCII-11 is not feasible owing to time constraints or because it is not feasible to use trained clinicians as interviewers. The Flexible Interview for ICD-11 (FLII-11) covers common and high-burden mental disorders, but is less comprehensive than the SCII-11. It is based on the algorithms and operationalizations developed for the SCII-11 but consists entirely of closed-ended (primarily yes/no questions), and is designed for use by lay interviewers with a limited amount of training. It will also be available for electronic administration as an open-access tool for WHO member states.

The Schedules for Clinical Assessment in Neuropsychiatry (SCAN) *(65,66)* is a semi-structured clinical interview used by trained clinicians to assess and diagnose mental disorders among adults, originally developed as a part of a joint project of WHO and the United States National Institute of Mental Health. The SCAN comprises a set of instruments, supported by manuals, and was originally developed around the Present State Examination, which assesses a wide range of symptoms likely to be manifested during a psychotic episode. The SCAN is designed to yield both ICD and DSM diagnoses, and has been translated into more than 35 languages. It requires extensive training by an approved training centre to administer. Its approach is different from that of the SCII-11, which attempts to assess the diagnostic requirements of mental disorders more directly via direct self-report of their essential features. Version 3 of the SCAN is currently being developed and will be fully compatible with the ICD-11. It will refer to the SCII-11 operationalizations in the formulation of its diagnostic algorithms, although its assessment methodology will remain distinct.

In addition, instruments focused on particular diagnoses as formulated in ICD-11 are being developed by WHO as well as by researchers external to WHO. For example, WHO is supporting the development of screening and diagnostic tools for gaming disorder *(67)*. Instruments not sponsored by WHO include several measures of personality disorder severity and trait domains based on ICD-11 developed by different research groups *(68–71)*. A self-report measure of ICD-11 post-traumatic stress disorder and complex post-traumatic stress disorder has been validated *(72)* and translated into over 25 languages. A scale designed to assess ICD-11 compulsive sexual behaviour disorder has been developed and validated *(73)*, and will be made available in up to 30 languages as part of a large international research project *(74)*. Ultimately, the use of the ICD-11 classification of mental, behavioural and neurodevelopmental disorders in research will depend on the development of validated measures for specific purposes, as illustrated by these examples, rather than on the development of a separate classification intended for research use.

Conclusion

As stated by the Advisory Group early in the development of ICD-11, "People are only likely to have access to the most appropriate mental health services when the conditions that define eligibility and treatment selection are supported by a precise, valid, and clinically useful classification system" *(5, p. 90)*. The ICD-11 classification of mental, behavioural and neurodevelopmental disorders and the CDDR have taken major steps in this direction. As a part of the first major revision of the ICD in three decades, the new diagnostic classification for mental disorders and the CDDR were developed based on comprehensive reviews of available scientific evidence and best clinical practices, using a participative global, multidisciplinary and multilingual process. Clinical utility and global applicability were guiding principles of this work, which was closely linked to a systematic programme of field studies involving thousands of clinicians around the globe.

The overall ICD-11 represents an enormous step forward, being based on and designed to be fully integratable with electronic health information infrastructure, which dramatically expands the capacities and flexibility of the classification system. It is likely to be the standard for global health information for some time – perhaps as long or longer than was ICD-10. A key aspect of WHO's plans regarding ICD-11 is that regular updates will occur every 2 years; these will provide an opportunity to modify the classification to reflect new knowledge and changing circumstances. It is anticipated that a greater number of changes will be made early on, as Member States gain experience in actually using the classification. This will provide an important mechanism for making refinements or clarifications to the classification of mental, behavioural and neurodevelopmental disorders should they be justified based on emerging evidence and clinical experience.

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Using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings

This chapter provides a basic orientation to applying the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders in clinical settings. As previously indicated, the CDDR are not intended to function as a manual for conducting clinical assessments. Rather, they are to be applied in the context of clinicians' broader understanding of the disorders they are assessing and the clinical competencies they have gained through appropriate education, training and experience. This chapter also contains information on relevant aspects of diagnostic coding, some of which are the result of important innovations in how ICD-11 categories are represented and relate to one another. This material on coding relates to the entire ICD-11 and is not specific to the chapter on mental, behavioural and neurodevelopmental disorders. Coding is discussed here as it affects the implementation of the CDDR.

This chapter includes a discussion of the following issues:

- components of the CDDR;
- making an ICD-11 diagnosis using the CDDR;
- co-occurring and mutually exclusive diagnoses;
- other specified and unspecified categories;
- other ICD-11 chapters relevant to diagnostic formulation of mental, behavioural and neurodevelopmental disorders; and
- ICD-11 diagnostic coding.

Components of the CDDR

A major improvement in the ICD-11 CDDR compared to the ICD-10 CDDG is the consistency of structure and information across major categories. The information provided for the main disorder categories in the CDDR is organized under the following headings:

- Essential (required) features
- Additional clinical features
- Boundary with normality (threshold)
- Course features
- Developmental presentations
- Culture-related features
- Sex- and/or gender-related features
- Boundaries with other disorders and conditions (differential diagnosis).

The information provided is based on reviews of the available evidence, and is intended to be useful in making diagnostic judgements about individual patients. These sections do not provide a summary of all available information about the topic in question, but rather focus on issues that may be specifically relevant to assigning a diagnosis to an individual patient. If a particular heading (e.g. developmental presentations, sex- and/or gender-related information) is not provided for a specific disorder, this is because insufficient evidence was identified as a basis for making clinically

relevant and broadly applicable statements. The following sections give a brief description of the information provided in each section of the CDDR for the main disorder categories.

Essential (required) features

This section provides guidance regarding the features needed to make the diagnosis confidently. The essential features represent those symptoms or characteristics that a clinician could reasonably expect to find in all cases of the disorder. In this sense, essential features resemble diagnostic criteria. However, artificial precision in diagnostic requirements, such as using exact counts of required symptoms and specific duration requirements as diagnostic cutoffs has generally been avoided unless these have been well established with appropriate global evidence. This allows for broader exercise of the professional's clinical judgement, depending on the characteristics of the patient – including cultural variations in presentation – and local circumstances. For example, it makes little sense to impose a rigid duration requirement of 6 months for a patient who has been experiencing the required symptoms for 5 months if the current visit represents the only opportunity that the patient is likely to have for appropriate treatment for the next year. This flexibility in language also allows the clinician to differentially weigh symptoms that are particularly severe and impairing, and to consider culturally specific "idioms of distress" that may differ somewhat in the way the patient understands and describes their experience but represent the same underlying phenomenon (e.g. somatic expressions of psychological distress).

Additional clinical features

This section describes additional clinical features that are not diagnostically determinative but are associated with the disorder frequently enough that they can help the clinician to recognize variations in disorder presentation. This section is also used for alerting the clinician to the likelihood that certain clinically important associated symptoms or co-occurring disorders may be present and require assessment and treatment.

Boundary with normality (threshold)

This section provides guidance regarding the differentiation of the disorder from normal variation in characteristics that may be continuous with, or similar to, the essential features of the disorder. This section often specifies aspects of the disorder that are indicative of its pathological nature and describes typical false-positives (i.e. clinical presentations that are similar in certain respects but are considered to be non-pathological). For many disorders, the differentiation from normality is based on the presence of significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Course features

This section provides clinically relevant information regarding the typical course of the disorder, which is defined broadly to include information about age of onset, whether the disorder is persistent or episodic, its likely progression or remission over time, and its temporal relationship to life stressors and other disorders.

Developmental presentations

This section describes how symptom presentations may differ according to the individual's developmental stage. Many disorders traditionally thought of as disorders of adulthood (e.g. depressive disorders) can present during childhood, and many disorders often thought of as disorders of childhood persist into adulthood, with alterations in their presentation. For example, presentations of attention deficit hyperactivity disorder in younger children often include excessive motor activity. In adolescents and adults with attention deficit hyperactivity disorder, the

equivalent phenomenon is experiencing feelings of physical restlessness or a sense of discomfort with being quiet or sitting still. Also included in this section are developmental variations that are more common in older adults, among whom many mental disorders are often underdiagnosed. This section also contains information about different patterns of co-occurring conditions and risks for associated sequelae according to developmental stage.

Culture-related features

This section provides information regarding cultural considerations that should be considered when making the diagnosis. This includes cultural variations in prevalence and symptoms of disorders, sociocultural mechanisms that may account for this variation, and descriptions of cultural concepts of distress that are relevant to diagnosis and treatment decisions. See the section on cultural factors in the Introduction for additional information.

Sex- and/or gender-related features

This section covers sex- and/or gender-related diagnostic issues, including sex- and/or gender-linked differences in symptom presentation, community prevalence and presentation in clinical settings.

Boundaries with other disorders and conditions (differential diagnosis)

This section lists other disorders that should be considered in the differential diagnosis – particularly those that share presenting symptoms or features. For each of these disorders, this section describes the features that differentiate it from the index disorder, providing guidance to the clinician about how to make this differentiation. Issues related to the concurrent diagnosis of the disorder being distinguished from the index disorder are also discussed in this section. The boundary descriptions generally cover all information conveyed by exclusion terms on the ICD-11 MMS platform.[3] Exclusion terms are often confusing to clinicians because they assume that they mean that the excluded condition cannot be diagnosed simultaneously with the index condition, which is not the case. Rather, an exclusion term in the ICD-11 MMS indicates that the condition excluded is not part of the condition described by the category, so that both conditions may be used at the same time if warranted. These considerations are covered more clearly and explicitly in the boundary descriptions found in this section of the CDDR.

Making an ICD-11 diagnosis using the CDDR

Consideration of essential (required) features

The diagnostic process starts with a consideration of whether the presentation meets the diagnostic requirements laid out in the essential (required) features section of the CDDR for the diagnosis under consideration. There are two types of essential features: those that must be present for the diagnostic requirements to be met and those that require a consideration of whether the symptoms may be better explained by other mental disorders that share presenting features. This aspect of the diagnostic evaluation includes a consideration of:

- particular symptoms that must be present (which may be expressed as a minimum number of symptoms from an item list – e.g. "Several of the following symptoms must be present");
- the minimum amount of time that symptoms need to have been present (e.g. "present…for a period of at least several months");
- frequency or proportion of the time that symptoms need to be present during that required period of time (e.g. "most of the time", "most of the day, nearly every day", "for more days than not", "more than 1 hour per day", "multiple incidents");

3 ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who.int/browse11/l-m/en#/).

- in some cases, whether the onset of symptoms meets a particular diagnostic requirement (e.g. "characterized by the rapid and concurrent onset of several characteristic symptoms"); and
- whether the symptoms meet any stated requirement regarding their impact on the individual's functioning ("symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning") or have resulted in "significant distress".

As noted, the CDDR generally avoid artificial precision in quantifying the exact number of items that must be present from a list of symptoms or specifying a precise duration requirement. Too rigidly applied, these can create barriers – for example, due to cultural variation or in contexts where an individual may have limited opportunities to access care. The essential features attempt to describe the relevant clinical phenomena clearly in order to allow for flexible application of the CDDR in establishing the presence of each diagnostic item. It is up to the diagnosing health professional to make a judgement about its presence or absence, considering the entire context of the clinical presentation. If the essential features do not mention a required duration for the symptoms, it is assumed that the symptoms should have been present for at least one month in order to assign the diagnosis.

Consideration of other disorders that may share presenting features

This aspect of the diagnostic evaluation includes whether the symptoms are best considered to be a manifestation of a disease or disorder classified outside of the mental, behavioural and neurodevelopmental disorders chapter (e.g. a sleep-wake disorder, a disease of the nervous system, or another medical condition). In cases where the symptoms are judged to be a direct pathophysiological consequence of a medical condition and the mental, behavioural or neurodevelopmental symptoms are a specific focus of clinical attention, a diagnosis of one of the secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere may be assigned, in addition to the appropriate diagnosis for the etiological medical condition. For example, depressive symptoms similar to those of a depressive episode that are judged to be due to hypothyroidism would warrant a diagnosis of secondary mood syndrome, with depressive symptoms in addition to hypothyroidism. However, certain disorders are diagnosed regardless of whether they are believed to be caused by a medical condition classified elsewhere, including neurocognitive disorders and certain neurodevelopmental disorders (i.e. disorders of intellectual development, autism spectrum disorder, stereotyped movement disorder).

The evaluation also includes whether the symptoms are due to the effects of a substance or medication on the central nervous system. If so, a diagnosis of one of the substance-induced mental disorders (e.g. alcohol-induced delirium, amfetamine-induced psychotic disorder) is likely to be appropriate. Other categories specifically linked to substances or medications include catatonia induced by substances or medications; amnestic disorder due to psychoactive substances, including medications; and dementia due to psychoactive substances, including medications.

Finally, the diagnostic evaluation includes whether there are other ICD-11 mental, behavioural and neurodevelopmental disorders that share features with the disorder under consideration, that might better account for the symptomatic presentation. Whether a particular disorder that *could* account for the symptoms in fact *better* accounts for them is a clinical judgement. For example, the essential features of social anxiety disorder, which are characterized by marked and excessive fear or anxiety that occurs in social situations, includes the diagnostic requirement that "the symptoms are not better accounted for by another mental disorder (e.g. agoraphobia, body dysmorphic disorder, olfactory reference disorder)". Each of these listed disorders may also involve the development of anxiety in social situations. For body dysmorphic disorder and olfactory reference disorder, the anxiety involves excessive self-consciousness about perceived defects in appearance or emitting an offensive body odour, respectively. In agoraphobia, the

anxiety is related to a fear of specific negative outcomes in social situations, such as panic attacks or other incapacitating (e.g. falling) or embarrassing (e.g. incontinence) physical symptoms. In making the clinical judgement of whether the symptoms of anxiety in social situations are better accounted for by one of these other disorders, the clinician takes into account factors such as the temporal sequence of the symptoms, which symptoms predominate, and the presence of other clinical features.

Consideration of boundary with normality (threshold)

For the most part, mental disorders occur on a severity continuum with no sharp division separating cases and non-cases (i.e. normality), making the differentiation between a mild case of the disorder and non-disordered normal variation potentially challenging. It is advisable to review this section because, in some cases, what might appear to be evidence of psychopathology may in fact be within the bounds of normality given the individual's developmental stage and cultural context. This section of the CDDR also points out common false-positive presentations.

Consideration of boundaries with other disorders and conditions (differential diagnosis)

This section of the CDDR is an extension and expansion of the "consideration of other disorders that may share presenting features" element of the essential features and provides a more comprehensive review of other disorders that should be considered in the differential diagnosis. The clinician should consider whether any of the disorders listed might explain the presenting symptoms.

Consideration of co-occurring and mutually exclusive diagnoses

ICD-11 diagnoses are generally assigned for every disorder for which the diagnostic requirements are met; that is, co-occurring diagnoses are typically permitted. However, there are specific situations in which the diagnostic requirements may be met for more than one disorder, typically because of symptom overlap, but the CDDR recommend making only a single diagnosis. In most cases, this is noted in the essential features but, in some cases, it is noted in the description of the differential diagnosis for that disorder in the section on boundaries with other disorders and conditions.

In the CDDR, recommendations against diagnosing two particular disorders together (i.e. co-occurrence) are generally made in one of the following ways.

- **"The symptoms do not meet the diagnostic requirements for …"; "The symptoms do not occur exclusively during episodes of …"; "The individual has never met the diagnostic requirements for …"**: these types of exclusionary statements are typically used if the symptomatic presentation of the disorder in question is already part of the definition of another disorder, and an additional diagnosis of the excluded disorder would be redundant.
- The first case ("symptoms do not meet diagnostic requirement for") prevents the assignment of both diagnoses if the diagnostic requirements for both disorders are met at the same time, and generally indicates that the other disorder should be diagnosed instead. For example, the CDDR for bulimia nervosa indicate that the diagnosis should only be assigned if the symptoms do not meet the diagnostic requirements for anorexia nervosa, so that individuals who maintain an excessively low body weight by reducing their energy intake through purging behaviour would be assigned only a single diagnosis of anorexia nervosa rather than diagnoses of both anorexia nervosa and bulimia nervosa. The presence of bulimia-like behaviour is indicated with the binge-purge pattern specifier applied to the diagnosis of anorexia nervosa.

- The second case ("symptoms do not occur exclusively during episodes of") similarly prevents diagnosing the disorder in question if its symptoms only occur during episodes of another disorder. For example, the CDDR for dissociative amnesia indicate that it should not be diagnosed if the dissociative memory loss occurs only during episodes of trance disorder; the amnestic symptoms are features of trance disorder rather than a separate condition.
- The third case ("individual has never met the diagnostic requirements for") prevents a diagnosis from being made if there is currently, or a history of, another disorder. For example, the CDDR for schizotypal disorder indicate that, in order to assign the diagnosis, the individual's past symptoms should never have met the diagnostic requirements for schizophrenia, schizoaffective disorder or delusional disorder. Similarly, recurrent depressive disorder is not diagnosed if the individual has ever experienced a manic, mixed or hypomanic episode.
- **"The symptoms are better accounted for by another mental disorder"**: many essential features sections include the requirement that the symptomatic presentation is not better accounted for by another mental disorder. This is typically the case when the symptomatic requirements of one disorder are also a possible manifestation of another disorder. An example is the occurrence of significant anxiety symptoms that develop in anticipation of attending school. If the anxiety is entirely accounted for by fear of speaking in class and/or social interaction with peers, a diagnosis of social anxiety disorder would be most appropriate. On the other hand, if the anxiety is entirely accounted for by fear of being separated from attachment figures while at school, a diagnosis of separation anxiety disorder would be appropriate. However, if the anxiety is related to both fear of negative evaluation by peers and separation from attachment figures, and all other diagnostic requirements for both disorders are met, then both diagnoses may be assigned. These distinctions typically require clinical judgement, in this example, about the relevant "focus of apprehension" or stimuli or situations that trigger the anxiety.
- **Symptomatic presentations accounted for by another disorder can sometimes be assigned an additional diagnosis if the second diagnosis is a separate focus of clinical attention**. Such recommendations may be noted in the section on boundaries with other disorders and conditions section. For example, stereotyped movements may be part of presentation of autism spectrum disorder: "repetitive and stereotyped motor movements, such as whole-body movements…" are listed as examples of "persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities" in the essential features of autism spectrum disorder. In the boundary with stereotyped movement disorder in the CDDR for autism spectrum disorder, however, it is noted that "although such stereotyped movements are typical in autism spectrum disorder, if they are severe enough to require additional clinical attention – for example, because of self-injury – a co-occurring diagnosis of stereotyped movement disorder may be warranted".
- **Finally, the boundaries with other disorders and conditions section may contain other recommendations regarding whether or not to diagnose more than one disorder.** For example, in the CDDR for generalized anxiety disorder, the boundary with depressive disorders states that "generalized anxiety disorder may co-occur with depressive disorders, but should only be diagnosed if the diagnostic requirements for generalized anxiety disorder were met prior to the onset of or following complete remission of a depressive episode".

Other specified and unspecified categories

By default, all groupings in ICD-11 contain what are called "residual categories", which include "other specified" categories with ICD-11 codes ending in "Y" (e.g. 6C7Y Other specified impulse control disorders) and "unspecified" categories with ICD-11 codes ending in "Z" (e.g. 6A8Z Mood disorder, unspecified). Occasionally, residual categories are "suppressed", or not listed, in the ICD-11 MMS because the other categories contained in the grouping are considered

to be exhaustive. For example, the grouping elimination disorders contains enuresis, encopresis and elimination disorder, unspecified; the other specified residual has been suppressed for this grouping and thus does not appear in the MMS.

The CDDR include essential (required) features for other specified categories at the grouping level (e.g. other specified mood disorder, other specified dissociative disorder). A particular other specified diagnosis should be applied when the presentation is judged to be a clinically significant mental disorder falling within a particular grouping of disorders (e.g. mood disorders, dissociative disorders) because it shares primary clinical features with these disorders but does not fulfil the diagnostic requirements of any of the other available categories. For example, a presentation that included all of the essential features of schizophrenia but had not met the 1-month duration requirement would appropriately be diagnosed as other specified primary psychotic disorder. A presentation characterized by abnormal eating or feeding behaviours that did not correspond to the essential features of any of the specific feeding and eating disorders categories but resulted in significant risk or damage to health, significant distress or significant impairment in functioning could be diagnosed as other specified feeding and eating disorder. Sometimes, other specified diagnoses may refer to recognizable syndromes that have not been included as separate categories in ICD-11 – for example, because they are very rare or are not sufficiently widely recognized as disorders. Ganser syndrome, for example, would be diagnosed as other specified dissociative disorder, and what is sometimes called "pathological demand avoidance" could be diagnosed as other specified disruptive behaviour or dissocial disorder if it did not meet the diagnostic requirements for oppositional defiant disorder. The characteristics of the presentation in other specified disorder should be *specified* in the clinical record.

Unspecified categories are most commonly used by professional coders when the clinician has provided insufficient information in the clinical record to assign a more specific diagnosis. In clinical situations, unspecified categories are appropriate only when insufficient information is available to make a more definitive diagnosis and, if possible, should be changed when additional information becomes available. In contrast to other specified categories, which are used when the clinician knows what the disorder is but there is no precisely corresponding code, unspecified categories are used when the clinician has been unable to arrive at a precise diagnostic determination. For example, an individual presenting in a hospital emergency department who is exhibiting hallucinations and delusions in the absence of evidence of substance use, delirium or dementia might be assigned a diagnosis of schizophrenia or other primary psychotic disorder, unspecified, until a more complete assessment can be conducted. Unspecified categories should not be used as an administrative shortcut when a more specific diagnosis can be assigned; this results in a major loss of clinical and statistical information.

Other ICD-11 chapters relevant to diagnostic formulation of mental, behavioural and neurodevelopmental disorders

Categories from any of the other 24 chapters in ICD-11 may be comorbid with a mental, behavioural or neurodevelopmental disorder, and thus relevant to their diagnostic formulation. However, the following chapters warrant particular attention:

Chapter 7. Sleep-wake disorders

The ICD-11 chapter on sleep-wake disorders brings together ICD-10 nonorganic sleep disorders (F51) with "organic" sleep disorders (G47) that were classified in the ICD-10 chapter on diseases of the nervous system, as well as categories previously included in several other chapters (i.e. endocrine, nutritional and metabolic diseases; diseases of the respiratory system; certain

conditions originating in the perinatal period). Sleep-wake disorders previously included in the ICD-10 chapter on mental and behavioural disorders include nightmare disorder, sleepwalking disorder, sleep terrors and "nonorganic" versions of insomnia disorders, hypersomnia disorders and circadian rhythm sleep-wake disorders (disorders of the sleep-wake schedule in ICD-10).

The unified ICD-11 chapter on sleep-wake disorders reflects the fact that the pathophysiology of most of these disorders is complex and includes both physiological and psychological/behavioural components. ICD-11 abandons outdated and incorrect assumptions about the etiology of sleep-wake disorders – in particular, the obsolete distinction between "organic" and "nonorganic" disorders. The chapter is intended to enhance patient care and public health by creating a more visible and accurate system that will enhance clinician awareness and improve diagnostic accuracy and treatment. Placement of these conditions in a separate chapter on sleep-wake disorders is in no way intended to indicate that they should not be diagnosed and treated by appropriately trained mental health professionals.

Chapter 8. Diseases of the nervous system

Diseases of the nervous system have a close relationship with mental, behavioural and neurodevelopmental disorders. Disorders in both chapters may affect cognition, emotional regulation or behaviour, and reflect dysfunctions in the psychological, biological or developmental processes. Given that mental, behavioural and neurodevelopmental disorders also affect the brain, in some instances the distinction between the two chapters is arbitrary and reflects professional tradition – especially the boundary between psychiatry and neurology – as much as biological or phenomenological differences between the conditions listed in each.

For some conditions, the psychological, behavioural or developmental syndrome is classified in the mental, behavioural and neurodevelopmental disorders chapter, while the underlying etiology may be classified in diseases of the nervous system. This includes disorders of intellectual development, autism spectrum disorder and stereotyped movement disorder in the neurodevelopmental disorders grouping; and delirium, mild neurocognitive disorder, amnestic disorder and dementia in the neurocognitive disorders grouping, all of which are diagnosed regardless of etiology. If the etiology is known, the corresponding diagnosis should also be assigned, which is often but not always in in the chapter on diseases of the nervous system. The other neurodevelopmental disorders (e.g. developmental learning disorder, developmental speech or language disorder, developmental motor coordination disorder) are generally not diagnosed if the symptoms are fully accounted for by a disease of the nervous system. When mental, behavioural or neurodevelopmental syndromes are judged to be a direct pathological consequence of a disease of the nervous system and are a specific focus of clinical attention, a diagnosis from the grouping secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere may be assigned. For example, a psychotic syndrome with prominent visual hallucinations that is judged to be the direct pathophysiological consequence of Parkinson disease would be diagnosed as secondary psychotic syndrome, with hallucinations along with a diagnosis of Parkinson disease.

Tic disorders and acquired aphasia with epilepsy (Landau-Kleffner syndrome) were classified in ICD-10 as emotional disorders with onset usually occurring in childhood and adolescence, but in ICD-11 have been moved to the chapter on diseases of the nervous system. In addition, movement disorders caused by medications (e.g. drug-induced parkinsonism, drug-induced dystonia), which are associated with certain medications commonly used to treat mental disorders, are included among the diseases of the nervous system.

Chapter 16. Diseases of the genitourinary system

This chapter includes a grouping of premenstrual disturbances that may include significant mood symptoms, such as depressed mood and irritability, as well as somatic and cognitive symptoms that may also occur in mood disorders. In particular, premenstrual dysphoric disorder is secondary-parented in the mood disorders grouping of ICD-11, and the CDDR for this entity are provided in this volume. In addition, while nearly all sexual dysfunctions classified as diseases of the genitourinary system in ICD-10 have been moved to the new ICD-11 chapter on conditions related to sexual health (see the next section), pain syndromes that are more generally associated with genital organs or the menstrual cycle are classified in Chapter 16.

Chapter 17. Conditions related to sexual health

Analogously to sleep-wake disorders, the ICD-10 classification of sexual dysfunctions was based on a Cartesian separation of "organic" and "nonorganic" conditions. Sexual dysfunctions not caused by organic disorder or disease (F52), which also include "nonorganic" versions of the sexual pain disorders vaginismus and dyspareunia, were classified in the ICD-10 chapter on mental and behavioural disorders, and most "organic" sexual dysfunctions are classified in the chapter on diseases of the genitourinary system. These have been brought together in a new unified classification of sexual dysfunctions and sexual pain disorders in the ICD-11 chapter on conditions related to sexual health. This approach is consistent with current, more integrative clinical approaches in sexual health, and recognizes the large body of evidence that the origin and maintenance of sexual dysfunctions and sexual pain disorders most often involves the interaction of physiological and psychological/behavioural factors. Reformulated versions of all sexual dysfunctions from the ICD-10 mental and behavioural disorders chapter can be found in the ICD-11 chapter on conditions related to sexual health, except for ICD-10 excessive sexual drive – a condition most closely related to compulsive sexual behaviour disorder in ICD-11 – which is included in the grouping of impulse control disorders. As with sleep-wake disorders, placement of these conditions in a separate chapter on conditions related to sexual health is not intended to indicate that they should not be diagnosed and treated by appropriately trained mental health professionals.

The ICD-11 chapter on conditions related to sexual health also includes gender incongruence, which represents a reformulation and renaming of ICD-10 gender identity disorders. There was substantial evidence that the nexus of stigmatization of transgender people and of mental disorders had contributed to a doubly burdensome situation for transgender and gender-variant people, and that stigma associated with the intersection of transgender status and mental disorders had contributed to precarious legal status, human rights violations and barriers to appropriate health care in this population. Although gender identity is clearly distinct from sex, this chapter appeared to offer the most broadly acceptable home for categories related to gender identity, while making it clear that they are no longer considered to be mental disorders. This position has been supported by a series of ICD-11 field studies. Gender incongruence was not proposed for elimination in ICD-11 because in many countries access to relevant health services is contingent on a qualifying diagnosis.

Chapter 21. Symptoms, signs or clinical findings, not elsewhere classified

The categories in this chapter are not considered to be disorders but rather provide descriptions of specific symptoms that may be used to describe the reason for a clinical encounter when a more precise diagnosis has not been established for various reasons. These categories may also be used to describe clinically important aspects of the individual's presentation when a diagnosis has been assigned.

A part of this chapter is a detailed and comprehensive listing of mental or behavioural symptoms, signs or clinical findings, which also includes definitions for each. These often represent important problems in their own right (e.g. avolition, demoralization, apathy, thought blocking). The categories from this section can be used to describe the clinical presentation in the absence of a definitive mental, behavioural or neurodevelopmental disorder diagnosis. In addition, these categories can be useful when a mental disorder diagnosis has been assigned, and the symptom being described has implications for treatment but is not an essential feature of the disorder itself and does not meet the diagnostic requirements for a co-occurring disorder. A listing of mental or behavioural symptoms, signs or clinical findings included in this chapter, with their definitions, is provided as part of the CDDR (p. 677).

Chapter 24. Factors influencing health status or contact with health services

Categories from this chapter may be used when a person seeks mental health services for a reason other than for symptoms of a mental disorder (e.g. counselling for a problem associated with unemployment), or when the problem influences the person's health status but is not in itself a mental disorder. A number of categories in this chapter are relevant to mental health professionals because they:

- represent a reason for a clinical encounter other than a mental disorder (e.g. counselling related to sexuality, counselling related to procreative management);
- are a focus of intervention (e.g. relationship problems and maltreatment – see p. 707);
- are important to consider in the differential diagnosis of mental disorders (e.g. uncomplicated bereavement, malingering); or
- are factors that may significantly contribute to the initiation or maintenance of disorders in the mental, behavioural and neurodevelopmental disorders chapter, including recognized social determinants of mental health (i.e. problems associated with finances, problems associated with employment or unemployment, target of perceived adverse discrimination or persecution).

A listing of factors influencing health status or contact with health services that are particularly relevant to mental health and mental health services is provided as part of the CDDR (p. 733).

ICD-11 diagnostic coding

Among the most important innovations of ICD-11 is its ability to capture much more clinical information associated with a particular diagnosis than was possible with ICD-10. Some of the ICD-11 coding features discussed in this section are designed for optimal use in the context of electronic information systems able to generate and interpret complex, multipart codes – for example, based on checklists completed by the health professional. However, some of these coding capabilities will also be useful to health professionals who are individually responsible for determining and recording diagnoses and diagnostic codes. Even when coding itself is done by professional coders, as in some countries and health systems, it is important for health professionals to understand the information needed to generate the most accurate and useful codes so that they are better able to provide this information as a part of the medical record, even if it is recorded by hand.

ICD-10 codes contained a letter of the alphabet in the first position, which indicated the chapter in which the category was classified. (The codes for ICD-10 mental and behavioural disorders all began with the letter "F".) This was sufficient for the 22 chapters in ICD-10. All the other characters in the ICD-10 codes were limited to numbers, which imposed a limit of 10 subdivisions

at each level corresponding to each digit in the diagnostic code. Moreover, ICD-10 allowed for the coding of only limited disorder-specific clinical information within a diagnostic code via the provision of specifiers and subtypes that could be codified in the fourth, fifth or sixth characters in an ICD-10 code.

ICD-11, like ICD-10 and its predecessors, also conveys diagnostic information based on the various positions and values of alphanumeric characters within a diagnostic code. The first character of an ICD-11 code indicates the top-level chapter; for example, if the first character is a "6", the code is found in the mental, behavioural and neurodevelopmental disorders chapter. The second and third characters taken together indicate the diagnostic class or grouping (e.g. 6A7 for depressive disorders, 6B0 for anxiety and fear-related disorders). The fourth character typically indicates the specific disorder within that class (e.g. 6A70 for single episode depressive disorder, 6A71 for recurrent depressive disorder), but in cases in which these number more than 10, letters of the alphabet are used after the digits 0–9 are exhausted. For example, the fourth character in the ICD-11 codes for disorders due to substance use indicates the substance class. Because ICD-11 recognizes 14 different specific substance classes, the fourth character codes for the last four substance classes required resorting to letters (e.g. the code for disorders due to use of volatile inhalants is 6C4B.)

The fifth character (following a decimal point) generally indicates subtypes or specifiers applicable to that diagnosis (e.g. 6A70.0 for single episode, mild; 6A70.1 for single episode, moderate, without psychotic symptoms; 6A70.2 for single episode, moderate, with psychotic symptoms). The ICD-11 codes for some disorders with more complicated systems for specifiers might require the use of a sixth character. For example, the fifth character for acute and transient psychotic disorder indicates whether it is the first episode (6A23.0) or one of multiple episodes (6A23.1). Indicating whether it is currently symptomatic or in remission requires a sixth character. That is, for 6A23.0 Acute and transient psychotic disorder, first episode, 6A23.00 is currently symptomatic; 6A23.01 is currently in partial remission; and 6A23.02 is currently in full remission. ICD-11 refers to this method of providing unique codes for all possible combinations of first or multiple episodes and currently symptomatic or partial remission or full remission for acute and transient psychotic disorder as "precoordination".

ICD-11 offers an additional coding convention that goes beyond just capturing clinical information within the confines of a single diagnostic code by allowing additional codes to be linked to the initial diagnostic code for the purpose of indicating additional clinically significant features. ICD-11 refers to this method of combining codes as "postcoordination". One type of postcoordination used in the chapter on mental, behavioural and neurodevelopmental disorders involves appending codes that indicate specific symptomatic or course presentations that are applicable only to diagnoses within a particular diagnostic grouping. These include symptomatic manifestations of primary psychotic disorders; symptomatic and course presentations for mood episodes in mood disorders; prominent personality traits or patterns in personality disorders; and behavioural or psychological disturbances in dementia. For example, the diagnostic codes indicating symptomatic and course presentations for mood episodes applicable only to mood disorders include the following

- 6A80.0 indicates the presence of prominent anxiety symptoms during a mood episode.
- 6A80.1 indicates that two or more panic attacks have occurred during a mood episode.
- 6A80.2 indicates that a current depressive episode is persistent.
- 6A80.3 indicates that a current depressive episode is characterized by melancholia.
- 6A80.4 indicates a seasonal pattern of mood episode onset and remission.
- 6A80.5 indicates a rapid cycling course (applicable only to bipolar type I and bipolar type II disorders).

The diagnostic code 6A71.3/6A80.3, for example, indicates recurrent depressive disorder, current episode severe, without psychotic symptoms (6A71.3), ***with*** melancholia (6A80.3).

Another form of postcoordination is through the use of "extension codes", which are generic codes that can be applied across the categories in the different chapters of ICD-11. Extension codes for severity – none (XS8H), mild (XS5W), moderate (XS0T) and severe (XS25) – are used in several places in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders. Extension codes are appended to the diagnostic code they are modifying using an ampersand (&). For example, 6D80&XS0T is the code for dementia due to Alzheimer disease (6D80) of moderate severity (XS0T). Extension codes can also be used to indicate a provisional diagnosis (XY7Z) or to designate a differential diagnosis (XY75). For example, 6A02&XY7Z is the code to indicate a provisional diagnosis (XY7Z) of autism spectrum disorder (6A02).

The coding for schizophrenia illustrates how a combination of precoordinated and postcoordinated codes, including extension codes for severity, can be used to characterize course and symptomatic manifestations more fully. Clinical course of schizophrenia is indicated using a combination of fifth-character codes ("0" for first episode, "1" for multiple episodes, "2" for continuous course) and sixth-character codes ("0" for currently symptomatic, "1" for in partial remission, "2" for in full remission). Dimensional profiles of current symptomatic manifestations can be indicated by adding codes from the symptomatic manifestations of primary psychotic disorders that represent specific symptom domains:

- 6A25.0 for positive symptoms;
- 6A25.1 for negative symptoms;
- 6A25.2 for depressive mood symptoms;
- 6A25.3 for manic mood symptoms;
- 6A25.4 for psychomotor symptoms; and
- 6A25.5 for cognitive symptoms.

The above codes for symptomatic manifestations of primary psychotic disorders can be used in combination with extension codes to indicate the severity of each symptom domain, respectively, thus providing a symptomatic profile of the presenting symptoms for schizophrenia for a particular individual at a particular point in time. The web-based browser for ICD-11 for MMS[4] can be used to construct the diagnostic coding for those disorders with complex combinations of specifiers and extensions. For example, schizophrenia, first episode, currently symptomatic with moderate positive symptoms, with severe negative symptoms, absent depressed mood symptoms, absent manic mood symptoms, mild psychomotor symptoms and severe cognitive symptoms yields the following combined diagnostic code:

6A20.00/6A25.0&XS0T/6A25.1&XS25/6A25.2&XS8H/6A25.3&XS8H/6A25.4&XS5W/6A25.5&XS25

As indicated, generating and interpreting this type of complex, multipart code will be most feasible for relatively sophisticated electronic health information systems. It is not expected that such complex codes will be used routinely by individual clinicians recording diagnoses by hand, for example.

Coding of mental disorders caused by health conditions not classified under mental, behavioural and neurodevelopmental disorders

ICD-11, as was the case with ICD-10, requires that two diagnostic codes be given for symptomatic presentations of mental disorders that are judged to be a manifestation of a health condition (i.e. disorder, disease or injury) classified outside Chapter 6.

4 ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who.int/browse11/l-m/en#/).

One code from the mental, behavioural and neurodevelopmental disorders chapter indicates the mental disorder diagnosis, and a second code indicates the etiological medical condition. Note that the CDDR often use the generic term "medical condition" to refer to health conditions that are not mental disorders (i.e. not classified in the chapter on mental, behavioural and neurodevelopmental disorders). This is only a shorthand; it is not intended to suggest that mental, behavioural and neurodevelopmental disorders are not health conditions.

The convention of double coding as it applies to the grouping of secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere involves assigning the code for the presumed underlying disorder or disease in combination with the code for the phenomenologically relevant secondary mental disorder. The earlier example of presentation consisting of depressive symptoms similar to those of a depressive episode that are judged to be due to hypothyroidism would be indicated by combining the diagnostic code for secondary mood syndrome, with depressive symptoms (6E62.0) with the appropriate diagnostic code from the hypothyroidism grouping – for example, transient congenital hypothyroidism (5A00.03), yielding the combination code 6E62.0/5A00.03. This coding convention also applies to neurocognitive disorders such as dementia due to different types of underlying diseases; for example, frontotemporal dementia requires two codes: 6D83 for the syndrome of frontotemporal dementia ***plus*** 8A23 frontotemporal lobar degeneration from Chapter 8 on diseases of the nervous system, yielding a combined code of 6D83/8A23. Importantly, the order of the codes being combined is not meaningful in this situation; it is not necessary to list the primary disorder first. That is, 6D83/8A23 has the same meaning as 8A23/6D83.

Secondary parenting

The ICD-11 classification is divided into 25 chapters, generally based on organ system (e.g. diseases of the digestive system), anatomic location (e.g. diseases of the ear and mastoid process), common pathophysiological process (e.g. certain infectious or parasitic disorders; neoplasms) or medical specialty (e.g. separating diseases of the nervous system from mental, behavioural and neurodevelopmental disorders). Many diseases in ICD-11 could have been placed in more than one chapter (e.g. pancreatic cancer could have been plausibly placed in either the diseases of the digestive system or the neoplasms chapter). ICD-11 acknowledges this fact by sometimes locating the same disorder in two (or more) chapters, with one of the chapters considered to be the "primary parent" and other chapter(s) termed "secondary parent(s)".

For example, the grouping of primary tics and tic disorders is listed in both Chapter 8 on diseases of the nervous system (within the movement disorders grouping) and the mental, behavioural and neurodevelopmental disorders chapter (within the neurodevelopmental disorders grouping). They are primary-parented in Chapter 8 on diseases of the nervous system and secondary-parented in the mental, behavioural and neurodevelopmental disorders chapter. The code number in both instances is the same and corresponds to the primary parent. For example, the code for Tourette syndrome is 8A05.00. The "8" in the first digit of the code indicates that it is primary-parented in Chapter 8 on diseases of the nervous system. The same code (8A05.00) is retained when Tourette syndrome appears as a part of the grouping of neurodevelopmental disorders in Chapter 6.

List of categories

ICD-11 Mental, behavioural and neurodevelopmental disorders

Note: the following list contains all the available codes in the ICD-11 chapter on mental, behavioural and neurodevelopmental disorders.

As described in the section of this manual on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders (p. 21), ICD-11 uses secondary parenting to cross-list categories from other parts of the classification that share important primary clinical features or other linkages with the disorders contained in a particular grouping. This most commonly involves substance-induced mental disorders and secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere, which are also classified in Chapter 6. In several cases, however, this involves categories from other chapters of ICD-11 (e.g. the inclusion of primary tics and tic disorders from Chapter 8 on disorders of the nervous system with neurodevelopmental disorders). These secondary-parented categories also appear in the list below with the groupings to which they are cross-listed, in grey font.

In ICD-11, postcoordination is a mechanism for allowing additional codes to be linked to the initial diagnostic code to identify additional clinically significant features of the clinical presentation. See the section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders (p. 21). Postcoordination options for each disorder grouping appear also appear in the list below, in boxes.

In some cases, ellipses (…) are used to improve the readability of the list by avoiding repetition of the disorder name. When used, ellipses signify the category name that appears in the level immediately above. For example, below 6A01.2 Developmental language disorder, the title for 6A01.20 appears as "… with impairment of receptive and expressive language" rather using the full name of the category, "6A01.20 Developmental language disorder with impairment of receptive and expressive language".

Neurodevelopmental disorders

6A00 Disorders of intellectual development

Specify severity:

6A00.0	Disorder of intellectual development, mild
6A00.1	Disorder of intellectual development, moderate
6A00.2	Disorder of intellectual development, severe
6A00.3	Disorder of intellectual development, profound
6A00.4	Disorder of intellectual development, provisional
6A00.Z	Disorder of intellectual development, unspecified

6A01 Developmental speech and language disorders

6A01.0 Developmental speech sound disorder
6A01.1 Developmental speech fluency disorder
6A01.2 Developmental language disorder
Specify areas of language impairment:
6A01.20 … with impairment of receptive and expressive language
6A01.21 … with impairment of mainly expressive language
6A01.22 … with impairment of mainly pragmatic language
6A01.23 … with other specified language impairment
6A01.Y Other specified developmental speech or language disorder
6A01.Z Developmental speech or language disorder, unspecified

6A02 Autism spectrum disorder

Specify whether there is a co-occurring disorder or intellectual development and level of functional language impairment:
6A02.0 … without disorder of intellectual development and with mild or no impairment of functional language
6A02.1 … with disorder of intellectual development and with mild or no impairment of functional language
6A02.2 … without disorder of intellectual development and with impaired functional language
6A02.3 … with disorder of intellectual development and with impaired functional language
6A02.5 … with disorder of intellectual development and with complete, or almost complete, absence of functional language
6A02.Y Other specified autism spectrum disorder
6A02.Z Autism spectrum disorder, unspecified

For all the above Autism Spectrum Disorder (6A02.*x*) categories, *specify* whether:
6A02.*x*0 without loss of previously acquired skills
6A02.*x*1 with loss of previously acquired skills

6A03 Developmental learning disorder

Specify area(s) of learning impairment:
6A03.0 … with impairment in reading
6A03.1 … with impairment in written expression
6A03.2 … with impairment in mathematics
6A03.3 … with other specified impairment of learning
6A03.Z … unspecified

6A04 Developmental motor coordination disorder

6A05 Attention deficit hyperactivity disorder

Specify characteristics of clinical presentation:
6A05.0 … with predominantly inattentive presentation
6A05.1 … with predominantly hyperactive-impulsive presentation
6A05.2 … with combined presentation
6A05.Y … with other specified presentation
6A05.Z … presentation unspecified

6A06 Stereotyped movement disorder

Specify presence of self-injurious behaviours:
6A06.0 … without self-injury
6A06.1 … with self-injury
6A06.Z … unspecified

6A0Y Other specified neurodevelopmental disorder

6A0Z Neurodevelopmental disorder, unspecified

Secondary-parented categories

From Chapter 8 on diseases of the nervous system:

8A05.0 Primary tics and tic disorders

8A05.00 Tourette syndrome
8A05.01 Chronic motor tic disorder
8A05.02 Chronic phonic tic disorder

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E60 Secondary neurodevelopmental syndrome

6E60.0 Secondary speech or language syndrome
6E60.Y Other specified secondary neurodevelopmental syndrome
6E60.Z Secondary neurodevelopmental syndrome, unspecified

Schizophrenia and other primary psychotic disorders

6A20 Schizophrenia

Specify course:

6A20.0 Schizophrenia, first episode
Specify current presentation:
6A20.00 … currently symptomatic
6A20.01 … in partial remission
6A20.02 … in full remission
6A20.0Z … unspecified

6A20.1 Schizophrenia, multiple episodes
Specify current presentation:
6A20.10 … currently symptomatic
6A20.11 … in partial remission
6A20.12 … in full remission
6A20.1Z … unspecified

6A20.2 Schizophrenia, continuous
Specify current presentation:
6A20.20 … currently symptomatic
6A20.21 … in partial remission
6A20.02 … in full remission
6A20.2Z … unspecified

6A20.Y Other specified episode of schizophrenia
6A20.Z Schizophrenia, episode unspecified

6A21 Schizoaffective disorder

Specify course:

6A21.0 Schizoaffective disorder, first episode
Specify current presentation:
6A20.00 … currently symptomatic
6A20.01 … in partial remission
6A20.02 … in full remission
6A20.0Z … unspecified

6A21.1 Schizoaffective disorder, multiple episodes
Specify current presentation:
6A21.10 … currently symptomatic
6A21.11 … in partial remission
6A21.12 … in full remission
6A21.1Z … unspecified

6A21.2 Schizoaffective disorder, continuous
Specify current presentation:
6A21.20 … currently symptomatic
6A21.21 … in partial remission
6A21.22 … in full remission
6A21.2Z … unspecified

6A21.Y Other specified schizoaffective disorder
6A21.Z Schizoaffective disorder, unspecified

6A22 Schizotypal disorder

6A23 Acute and transient psychotic disorder

Specify course:
6A23.0 Acute and transient psychotic disorder, first episode
Specify current presentation:
6A23.00 … currently symptomatic
6A23.01 … in partial remission
6A23.02 … in full remission
6A23.0Z … unspecified

6A23.1 Acute and transient psychotic disorder, multiple episodes
Specify current presentation:
6A23.10 … currently symptomatic
6A23.11 … in partial remission
6A23.12 … in full remission
6A23.1Z … unspecified

6A23.Y Other specified acute and transient psychotic disorder
6A23.Z Acute and transient psychotic disorder, unspecified

6A24 Delusional disorder

Specify current presentation:
6A24.0 … currently symptomatic
6A24.1 … in partial remission
6A24.2 … in full remission
6A24.Z … unspecified

6A2Y Other specified primary psychotic disorder

6A2Z Schizophrenia or other primary psychotic disorder, unspecified

Postcoordination for schizophrenia and other primary psychotic disorders
For all above categories in the schizophrenia and other primary psychotic disorders grouping, specify symptomatic manifestations of primary psychotic disorders to describe current clinical presentation:

6A25.0	Positive symptoms	
	Specify severity:	
	6A25.0&XS8H	None
	6A25.0&XS5W	Mild
	6A25.0&XS0T	Moderate
	6A25.0&XS25	Severe
6A25.1	Negative symptoms	
	Specify severity:	
	6A25.1&XS8H	None
	6A25.1&XS5W	Mild
	6A25.1&XS0T	Moderate
	6A25.1&XS25	Severe
6A25.2	Depressive mood symptoms	
	Specify severity:	
	6A25.2&XS8H	None
	6A25.2&XS5W	Mild
	6A25.2&XS0T	Moderate
	6A25.2&XS25	Severe
6A25.3	Manic mood symptoms	
	Specify severity:	
	6A25.3&XS8H	None
	6A25.3&XS5W	Mild
	6A25.3&XS0T	Moderate
	6A25.3&XS25	Severe
6A25.4	Psychomotor symptoms	
	Specify severity:	
	6A25.4&XS8H	None
	6A25.4&XS5W	Mild
	6A25.4&XS0T	Moderate
	6A25.4&XS25	Severe
6A25.5	Cognitive symptoms	
	Specify severity:	
	6A25.5&XS8H	None
	6A25.5&XS5W	Mild
	6A25.5&XS0T	Moderate
	6A25.5&XS25	Severe

Secondary-parented categories

From disorders due to substance use:

Substance-induced psychotic disorders

Specify substance class:

6C40.6 Alcohol-induced psychotic disorder

Specify clinical presentation:
6C40.60 … with hallucinations
6C40.61 … with delusions
6C40.62 … with mixed psychotic symptoms
6C40.6Z … unspecified

6C41.6 Cannabis-induced psychotic disorder

6C42.6 Synthetic cannabinoid-induced psychotic disorder

6C43.6 Opioid-induced psychotic disorder

6C44.6 Sedative, hypnotic or anxiolytic-induced psychotic disorder

6C45.6 Cocaine-induced psychotic disorder

Specify clinical presentation:
6C45.60 … with hallucinations
6C45.61 … with delusions
6C45.62 … with mixed psychotic symptoms
6C45.6Z … unspecified

6C46.6 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone

Specify clinical presentation:
6C46.60 … with hallucinations
6C46.61 … with delusions
6C46.62 … mixed psychotic symptoms
6C46.6Z … unspecified

6C47.6 Synthetic cathinone-induced psychotic disorder

Specify clinical presentation:
6C47.60 … with hallucinations
6C47.61 … with delusions
6C47.62 … with mixed psychotic symptoms
6C47.6Z … unspecified

6C49.5 Hallucinogen-induced psychotic disorder

6C4B.6 Volatile inhalant-induced psychotic disorder

6C4C.6 MDMA or related drug-induced psychotic disorder

6C4D.5 Dissociative drug-induced psychotic disorder, including ketamine and phencyclidine (PCP)

6C4E.6 Psychotic disorder induced by other specified psychoactive substance

6C4F.6 Psychotic disorder induced by multiple specified psychoactive substances

6C4G.6 Psychotic disorder induced by unknown or unspecified specified psychoactive substances

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E61 Secondary psychotic syndrome

Specify clinical presentation:
6E61.0 … with hallucinations
6E61.1 … with delusions
6E61.2 … with hallucinations and delusions
6E61.3 … with unspecified symptoms

Catatonia

6A40 Catatonia associated with another mental disorder

6A41 Catatonia induced by substances or medications

6A4Z Catatonia, unspecified

Secondary-parented category

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E69 Secondary catatonia syndrome

Mood disorders

Bipolar and related disorders

6A60 Bipolar type I disorder

Specify type of current or most recent episode and/or remission:

6A60.0 … current episode manic, without psychotic symptoms
6A60.1 … current episode manic, with psychotic symptoms
6A60.2 … current episode hypomanic
6A60.3 … current episode depressive, mild
6A60.4 … current episode depressive, moderate, without psychotic symptoms
6A60.5 … current episode depressive, moderate, with psychotic symptoms
6A60.6 … current episode depressive, severe, without psychotic symptoms
6A60.7 … current episode depressive, severe, with psychotic symptoms
6A60.8 … current episode depressive, unspecified severity
6A60.9 … current episode mixed, without psychotic symptoms
6A60.A … current episode mixed, with psychotic symptoms
6A60.B … currently in partial remission, most recent episode manic or hypomanic
6A60.C … currently in partial remission, most recent episode depressive
6A60.D … currently in partial remission, most recent episode mixed
6A60.E … currently in partial remission, most recent episode unspecified
6A60.F … currently in full remission
6A60.Y Other specified bipolar type I disorder
6A60.Z Bipolar type I disorder, unspecified

Postcoordination for bipolar type I disorder:

For all above bipolar type I disorder categories, *specify* additional features of current presentation or course by using additional code(s) if applicable:

6A80.0 with prominent anxiety symptoms
6A80.1 with panic attacks
6A80.2 current depressive episode persistent
6A80.3 current depressive episode with melancholia
6A80.4 with seasonal pattern of mood episode onset
6A80.5 with rapid cycling

For all above bipolar type I disorder current or most recent episodes, *specify* if episode onset was during pregnancy or within 6 weeks after delivery by using additional code:

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

6A61 Bipolar type II disorder

Specify type of current or most recent episode and/or remission:

6A61.0 … current episode hypomanic
6A61.1 … current episode depressive, mild
6A61.2 … current episode depressive, moderate, without psychotic symptoms
6A61.3 … current episode depressive, moderate, with psychotic symptoms
6A61.4 … current episode depressive, severe, without psychotic symptoms
6A61.5 … current episode depressive, severe, with psychotic symptoms
6A61.6 … current episode depressive, unspecified severity
6A61.7 … currently in partial remission, most recent episode hypomanic
6A61.8 … currently in partial remission, most recent episode depressive
6A61.9 … currently in partial remission, most recent episode unspecified
6A61.A … currently in full remission
6A61.Y Other specified bipolar type II disorder
6A61.Z Bipolar type II disorder, unspecified

Postcoordination for bipolar type II disorder

For all above bipolar type II disorder categories, *specify* additional features of current presentation or course by using additional code(s) if applicable:

6A80.0 with prominent anxiety symptoms
6A80.1 with panic attacks
6A80.2 current depressive episode persistent
6A80.3 current depressive episode with melancholia
6A80.4 with seasonal pattern of mood episode onset
6A80.5 with rapid cycling

For all above bipolar type II disorder current or most recent episodes, specify if episode onset was during pregnancy or within 6 weeks after delivery by using additional code:

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

6A62 Cyclothymic disorder

6A6Y Other specified bipolar or related disorder

6A6Z Bipolar or related disorder, unspecified

Depressive disorders

6A70 Single episode depressive disorder

Specify severity or remission of current episode:

6A70.0 … mild
6A70.1 … moderate, without psychotic symptoms
6A70.2 … moderate, with psychotic symptoms
6A70.3 … severe, without psychotic symptoms
6A70.4 … severe, with psychotic symptoms
6A70.5 … unspecified severity
6A70.6 … currently in partial remission
6A70.7 … currently in full remission
6A70.Y Other specified single episode depressive disorder
6A70.Z Single episode depressive disorder, unspecified

Postcoordination for single episode depressive disorder

For all above single episode depressive disorder categories, *specify* additional features of current presentation or course by using additional code(s) if applicable:

6A80.0 with prominent anxiety symptoms
6A80.1 with panic attacks
6A80.2 current depressive episode persistent
6A80.3 current depressive episode with melancholia
6A80.4 with seasonal pattern of mood episode onset

For all above single episode depressive disorder current or most recent episodes, *specify* if episode onset was during pregnancy or within 6 weeks after delivery by using additional code:

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

6A71 Recurrent depressive disorder

Specify severity or remission of current episode:

6A71.0 … current episode mild
6A71.1 … current episode moderate, without psychotic symptoms
6A71.2 … current episode moderate, with psychotic symptoms
6A71.3 … current episode severe, without psychotic symptoms

6A71.4 … current episode severe, with psychotic symptoms
6A71.5 … current episode, unspecified severity
6A71.6 … currently in partial remission
6A71.7 … currently in full remission
6A71.Y Other specified recurrent depressive disorder
6A71.Z Recurrent depressive disorder, unspecified

Postcoordination for recurrent depressive disorder

For all above recurrent depressive disorder categories, *specify* additional features of current presentation or course by using additional code(s) if applicable:

6A80.0 with prominent anxiety symptoms
6A80.1 with panic attacks
6A80.2 current depressive episode persistent
6A80.3 current depressive episode with melancholia
6A80.4 with seasonal pattern of mood episode onset

For all above recurrent depressive disorder current or most recent episodes, *specify* if episode onset was during pregnancy or within 6 weeks after delivery by using additional code:

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

6A72 Dysthymic disorder

6A73 Mixed depressive and anxiety disorder

6A7Y Other specified depressive disorder

6A7Z Depressive disorder, unspecified

6A8Y Other specified mood disorder

6A8Z Mood disorder, unspecified

Secondary-parented categories

From disorders due to substance use:

Substance-induced mood disorders

Specify substance class:

6C40.70 Alcohol-induced mood disorder

Specify clinical presentation:
6C40.700 … with depressive symptoms
6C40.701 … with manic symptoms
6C40.702 … with mixed depressive and manic symptoms
6C40.70Z … unspecified

6C41.70 Cannabis-induced mood disorder

Specify clinical presentation:
6C41.700 … with depressive symptoms
6C41.701 … with manic symptoms
6C41.702 … with mixed depressive and manic symptoms
6C41.70Z … unspecified

6C42.70 Synthetic cannabinoid-induced mood disorder

Specify clinical presentation:
6C42.700 … with depressive symptoms
6C42.701 … with manic symptoms
6C42.702 … with mixed depressive and manic symptoms
6C42.70Z … unspecified

6C43.70 Opioid-induced mood disorder

Specify clinical presentation:
6C43.700 … with depressive symptoms
6C43.701 … with manic symptoms
6C43.702 … with mixed depressive and manic symptoms
6C43.70Z … unspecified

6C44.70 Sedative, hypnotic or anxiolytic-induced mood disorder

Specify clinical presentation:
6C44.700 … with depressive symptoms
6C44.701 … with manic symptoms
6C44.702 … with mixed depressive and manic symptoms
6C44.70Z … unspecified

6C45.70 Cocaine-induced mood disorder

Specify clinical presentation:
6C45.700 … with depressive symptoms
6C45.701 … with manic symptoms
6C45.702 … with mixed depressive and manic symptoms
6C45.70Z … unspecified

6C46.70 Stimulant-induced mood disorder, including amfetamines, methamfetamine and methcathinone

Specify clinical presentation:
6C46.700 … with depressive symptoms
6C46.701 … with manic symptoms
6C46.702 … with mixed depressive and manic symptoms
6C46.70Z … unspecified

6C47.70 Synthetic cathinone-induced mood disorder

Specify clinical presentation:
6C47.700 … with depressive symptoms
6C47.701 … with manic symptoms
6C47.702 … with mixed depressive and manic symptoms
6C47.70Z … unspecified

6C49.60 Hallucinogen-induced mood disorder

Specify clinical presentation:
6C49.700 … with depressive symptoms
6C49.701 … with manic symptoms
6C49.702 … with mixed depressive and manic symptoms
6C49.70Z … unspecified

6C4B.70 Volatile inhalant-induced mood disorder

Specify clinical presentation:
6C4B.700 … with depressive symptoms
6C4B.701 … with manic symptoms
6C4B.702 … with mixed depressive and manic symptoms
6C4B.70Z … unspecified

6C4C.70 MDMA or related drug-induced mood disorder, including MDA

Specify clinical presentation:
6C4C.700 … with depressive symptoms
6C4C.701 … with manic symptoms
6C4C.702 … with mixed depressive and manic symptoms
6C4C.70Z … unspecified

6C4D.60 Dissociative drug-induced mood disorder, including ketamine and PCP

Specify clinical presentation:
6C4D.700 … depressive symptoms
6C4D.701 … with manic symptoms
6C4D.702 … with mixed depressive and manic symptoms
6C4D.70Z … unspecified

6C4E.70 Mood disorder induced by other specified psychoactive substance

Specify clinical presentation:
6C4E.700 … with depressive symptoms
6C4E.701 … with manic symptoms
6C4E.702 … with mixed depressive and manic symptoms
6C4E.70Z … unspecified

6C4F.70 Mood disorder induced by multiple specified psychoactive substances

Specify clinical presentation:
6C4F.700 … with depressive symptoms
6C4F.701 … with manic symptoms
6C4F.702 … with mixed depressive and manic symptoms
6C4F.70Z … unspecified

6C4G.70 Mood disorder induced by unknown or unspecified psychoactive substances

Specify clinical presentation:
6C4G.700 … with depressive symptoms
6C4G.701 … with manic symptoms

6C4G.702 … with mixed depressive and manic symptoms
6C4G.70Z … unspecified

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E62 Secondary mood syndrome

Specify clinical presentation:
6E62.0 … with depressive symptoms
6E62.1 … with manic symptoms
6E62.2 … with mixed symptoms
6E62.3 … with unspecified symptoms

Anxiety and fear-related disorders

6B00 Generalized anxiety disorder

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B00/MB23.H Generalized anxiety disorder with panic attacks

6B01 Panic disorder

6B02 Agoraphobia

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B02/MB23.H Agoraphobia with panic attacks

6B03 Specific phobia

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B03/MB23.H Specific phobia with panic attacks

6B04 Social anxiety disorder

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B04/MB23.H Social anxiety disorder with panic attacks

6B05 Separation anxiety disorder

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B05/MB23.H Separation anxiety disorder with panic attacks

6B06 Selective mutism

6B0Y Other specified anxiety or fear-related disorder

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B0Y/MB23.H Other specified anxiety and fear-related disorder with panic attacks

6B0Z Anxiety or fear-related disorder, unspecified

Specify presence of panic attacks without co-occurring panic disorder diagnosis
6B0Z/MB23.H Anxiety or fear-related disorder, unspecified, with panic attacks

Secondary-parented categories

From obsessive-compulsive and related disorders:

6B23 Hypochondriasis (health anxiety disorder)

Specify level of insight:
6B23.0 Hypochondriasis with fair to good insight
6B23.1 Hypochondriasis with poor to absent insight

From disorders due to substance use:

Substance-induced anxiety disorders

Specify substance class:

6C40.71 Alcohol-induced anxiety disorder

6C41.71 Cannabis-induced anxiety disorder

6C42.71 Synthetic cannabinoid-induced anxiety disorder

6C43.71 Opioid-induced anxiety disorder

6C44.71	Sedative, hypnotic or anxiolytic-induced anxiety disorder
6C45.71	Cocaine-induced anxiety disorder
6C46.71	Stimulant-induced anxiety disorder, including amfetamines, methamfetamine and methcathinone
6C47.71	Synthetic cathinone-induced anxiety disorder
6C48.71	Caffeine-induced anxiety disorder
6C49.71	Hallucinogen-induced anxiety disorder
6C40.71	Volatile inhalant-induced anxiety disorder
6C4C.71	MDMA or related drug-induced anxiety disorder
6C4D.71	Dissociative drug-induced anxiety disorder, including ketamine and PCP
6C4E.71	Anxiety disorder induced by other specified psychoactive substance
6C4F.71	Anxiety disorder induced by multiple specified psychoactive substances
6C4G.71	Anxiety disorder induced by unknown or unspecified specified psychoactive substances

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E63	Secondary anxiety syndrome

Obsessive-compulsive and related disorders

6B20 Obsessive-compulsive disorder

Specify level of insight:

6B20.0 Obsessive-compulsive disorder with fair to good insight
6B20.1 Obsessive-compulsive disorder with poor to absent insight
6B20.Z Obsessive-compulsive disorder, unspecified

6B21 Body dysmorphic disorder

Specify level of insight:

6B21.0 Body dysmorphic disorder with fair to good insight
6B21.1 Body dysmorphic disorder with poor to absent insight
6B21.Z Body dysmorphic disorder, unspecified

6B22 Olfactory reference disorder

Specify level of insight:

6B22.0 Olfactory reference disorder with fair to good insight
6B22.1 Olfactory reference disorder with poor to absent insight
6B22.Z Olfactory reference disorder, unspecified

6B23 Hypochondriasis (health anxiety disorder)

Specify level of insight:

6B23.0 Hypochondriasis with fair to good insight
6B23.1 Hypochondriasis with poor to absent insight
6B23.Z Hypochondriasis, unspecified

6B24 Hoarding disorder

Specify level of insight:

6B24.0 Hoarding disorder with fair to good insight
6B24.1 Hoarding disorder with poor to absent insight
6B24.Z Hoarding disorder, unspecified

6B25 Body-focused repetitive behaviour disorders

6B25.0 Trichotillomania (hair-pulling disorder)
6B25.1 Excoriation (skin-picking) disorder

6B25.Y Other specified body-focused repetitive behaviour disorder
6B25.Z Body-focused repetitive behaviour disorder, unspecified

6B2Y Other specified obsessive-compulsive or related disorder

6B2Z Obsessive-compulsive or related disorder, unspecified

Secondary-parented categories

From Chapter 8 on diseases of the nervous system:

8A05.00 Tourette syndrome

From disorders due to substance use:

Substance-induced obsessive-compulsive and related disorders

Specify substance class:
6C45.72 Cocaine-induced obsessive-compulsive or related disorder
6C46.72 Stimulant-induced obsessive-compulsive or related disorder, including amfetamines, methamfetamine and methcathinone
6C47.72 Synthetic cathinone-induced obsessive-compulsive or related syndrome
6C4E.72 Obsessive-compulsive or related disorder induced by other specified psychoactive substance
6C4F.72 Obsessive-compulsive or related disorder induced by multiple specified psychoactive substances
6C4G.72 Obsessive-compulsive or related disorder induced by unknown or unspecified psychoactive substances

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E64 Secondary obsessive-compulsive or related syndrome

Disorders specifically associated with stress

6B40	Post-traumatic stress disorder
6B41	Complex post-traumatic stress disorder
6B42	Prolonged grief disorder
6B43	Adjustment disorder
6B44	Reactive attachment disorder
6B45	Disinhibited social engagement disorder
6B4Y	Other specified disorder specifically associated with stress
6B4Z	Disorder specifically associated with stress, unspecified

Secondary-parented category

From Chapter 21 on factors influencing health status or contact with health services

QE84	Acute stress reaction

Dissociative disorders

6B60 Dissociative neurological symptom disorder

Specify clinical presentation:

6B60.0 … with visual disturbance
6B60.1 … with auditory disturbance
6B60.2 … with vertigo or dizziness
6B60.3 … with other sensory disturbance
6B60.4 … with non-epileptic seizures
6B60.5 … with speech disturbance
6B60.6 … with paresis or weakness
6B60.7 … with gait disturbance
6B60.8 … with movement disturbance
- 6B60.80 … with chorea
- 6B60.81 … with myoclonus
- 6B60.82 … with tremor
- 6B60.83 … with dystonia
- 6B60.84 … with facial spasm
- 6B60.85 … with parkinsonism
- 6B60.8Y … with other specified movement disturbance
- 6B60.8Z … with unspecified movement disturbance

6B60.9 … with cognitive symptoms
6B60.Y … with other specified symptoms
6B60.Z … with unspecified symptoms

6B61 Dissociative amnesia

Specify presence of dissociative fugue:

6B61.0 … with dissociative fugue
6B61.1 … without dissociative fugue
6B61.Z … unspecified

6B62 Trance disorder

6B63 Possession trance disorder

6B64 Dissociative identity disorder

6B65 Partial dissociative identity disorder

6B66 Depersonalization-derealization disorder

6B6Y Other specified dissociative disorder

6B6Z Dissociative disorder, unspecified

Secondary-parented category

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E65 Secondary dissociative syndrome

Feeding and eating disorders

6B80 Anorexia nervosa

Specify underweight status:

6B80.0 Anorexia nervosa with significantly low body weight
Specify pattern of weight-related behaviours:
6B80.00 … restricting pattern
6B80.01 … binge-purge pattern
6B80.0Z … unspecified

6B80.1 Anorexia nervosa with dangerously low body weight
Specify pattern of weight-related behaviours:
6B80.10 … restricting pattern
6B80.11 … binge-purge pattern
6B80.1Z … unspecified

6B80.2 Anorexia nervosa in recovery with normal body weight

6B80.Y Other specified anorexia nervosa

6B80.Z Anorexia nervosa, unspecified

6B81 Bulimia nervosa

6B82 Binge-eating disorder

6B83 Avoidant-restrictive food intake disorder

6B84 Pica

6B85 Rumination-regurgitation disorder

6B8Y Other specified feeding or eating disorder

6B8Z Feeding or eating disorder, unspecified

Elimination disorders

6C00 Enuresis

Specify night-time or daytime occurrence:

6C00.0 Nocturnal enuresis
6C00.1 Diurnal enuresis
6C00.2 Nocturnal and diurnal enuresis
6C00.Z Enuresis, unspecified

6C01 Encopresis

Specify pattern of faecal soiling:

6C01.0 …with constipation and overflow incontinence
6C01.1 …without constipation and overflow incontinence
6C01.Z …unspecified

6B80 Elimination disorder, unspecified

Disorders of bodily distress or bodily experience

6C20 Bodily distress disorder

Specify level of severity:
6C20.0 Mild bodily distress disorder
6C20.1 Moderate bodily distress disorder
6C20.2 Severe bodily distress disorder
6C20.Z Bodily distress disorder, unspecified

6C21 Body integrity dysphoria

6C2Y Other specified disorder of bodily distress or bodily experience

6C2Z Disorder of bodily distress or bodily experience, unspecified

Disorders due to substance use and addictive behaviours

Disorders due to substance use

6C40 Disorders due to use of alcohol

6C40.0 Episode of harmful use of alcohol

6C40.1 Harmful pattern of use of alcohol
Specify pattern:
6C40.10 … episodic
6C40.11 … continuous
6C40.1Z … unspecified

6C40.2 Alcohol dependence
Specify pattern of substance use or remission:
6C40.20 … current use, continuous
6C40.21 … current use, episodic
6C40.22 … early full remission
6C40.23 … sustained partial remission
6C40.24 … sustained full remission
6C40.2Z … unspecified

6C40.3 Alcohol intoxication
Specify severity:
6C40.3&XS5W Alcohol intoxication, mild
6C40.3&XS0T Alcohol intoxication, moderate
6C40.3&XS25 Alcohol intoxication, severe

6C40.4 Alcohol withdrawal
Specify clinical presentation:
6C40.40 … uncomplicated
6C40.41 … with perceptual disturbances
6C40.42 … with seizures
6C40.43 … with perceptual disturbances and seizures
6C40.4Z … unspecified

6C40.5 Alcohol-induced delirium

6C40.6 Alcohol-induced psychotic disorder
Specify clinical presentation:
6C40.60 … with hallucinations
6C40.61 … with delusions
6C40.62 … with mixed psychotic symptoms
6C40.6Z … unspecified

6C40.70 Alcohol-induced mood disorder
Specify clinical presentation:
6C40.700 … with depressive symptoms
6C40.701 … with manic symptoms
6C40.702 … with mixed depressive and manic symptoms
6C40.70Z … unspecified

6C40.71 Alcohol-induced anxiety disorder

6C40.Y Other specified disorder due to use of alcohol

6C40.Z Disorders due to use of alcohol, unspecified

6C41 Disorders due to use of cannabis

6C41.0 Episode of harmful use of cannabis

6C41.1 Harmful pattern of use of cannabis
Specify pattern:
6C41.10 … episodic
6C41.11 … continuous
6C41.1Z … unspecified

6C41.2 Cannabis dependence
Specify pattern of substance use or remission:
6C41.20 … current use
6C41.21 … early full remission
6C41.22 … sustained partial remission
6C41.23 … sustained full remission
6C41.2Z … unspecified

6C41.3 Cannabis intoxication
Specify severity:
6C41.3&XS5W Cannabis intoxication, mild
6C41.3&XS0T Cannabis intoxication, moderate
6C41.3&XS25 Cannabis intoxication, severe

6C41.4 Cannabis withdrawal

6C41.5 Cannabis-induced delirium

6C41.6 Cannabis-induced psychotic disorder

6C41.70 Cannabis-induced mood disorder
Specify clinical presentation:
6C41.700 … with depressive symptoms
6C41.701 … with manic symptoms
6C41.702 … with mixed depressive and manic symptoms
6C41.70Z … unspecified

6C41.71 Cannabis-induced anxiety disorder

6C41.Y Other specified disorder due to use of cannabis

6C41.Z Disorder due to use of cannabis, unspecified

6C42 Disorders due to use of synthetic cannabinoids

6C42.0 Episode of harmful use of synthetic cannabinoids

6C42.1 Harmful pattern of use of synthetic cannabinoids
Specify pattern:
6C42.10 … episodic
6C42.11 … continuous
6C42.1Z … unspecified

6C42.2 Synthetic cannabinoid dependence
Specify pattern of substance use or remission:
6C42.20 … current use
6C42.21 … early full remission
6C42.22 … sustained partial remission
6C42.23 … sustained full remission
6C42.2Z … unspecified

6C42.3 Synthetic cannabinoid intoxication
Specify severity:
6C42.3&XS5W Synthetic cannabinoid intoxication, mild
6C42.3&XS0T Synthetic cannabinoid intoxication, moderate
6C42.3&XS25 Synthetic cannabinoid intoxication, severe

6C42.4 Synthetic cannabinoid withdrawal

6C42.5 Synthetic cannabinoid-induced delirium

6C42.6 Synthetic cannabinoid-induced psychotic disorder

6C42.70 Synthetic cannabinoid-induced mood disorder
Specify clinical presentation:
6C42.700 … with depressive symptoms
6C42.701 … with manic symptoms
6C42.702 … with mixed depressive and manic symptoms
6C42.70Z … unspecified

6C42.71 Synthetic cannabinoid-induced anxiety disorder

6C42.Y Other specified disorder due to use of synthetic cannabinoids

6C42.Z Disorder due to use of synthetic cannabinoids, unspecified

6C43 Disorders due to use of opioids

6C43.0 Episode of harmful use of opioids

6C43.1 Harmful pattern of use of opioids
Specify pattern:
6C43.10 … episodic
6C43.11 … continuous
6C43.1Z … unspecified

6C43.2 Opioid dependence
Specify pattern of substance use or remission:
6C43.20 … current use
6C43.21 … early full remission
6C43.22 … sustained partial remission
6C43.23 … sustained full remission
6C43.2Z … unspecified

6C43.3 Opioid intoxication
Specify severity:
6C43.3&XS5W Opioid intoxication, mild
6C43.3&XS0T Opioid intoxication, moderate
6C43.3&XS25 Opioid intoxication, severe

6C43.4 Opioid withdrawal

6C43.5 Opioid-induced delirium

6C43.6 Opioid-induced psychotic disorder

6C43.70 Opioid-induced mood disorder
Specify clinical presentation:
6C43.700 … with depressive symptoms
6C43.701 … with manic symptoms
6C43.702 … with mixed depressive and manic symptoms
6C43.70Z … unspecified

6C43.71 Opioid-induced anxiety disorder

6C43.Y Other specified disorder due to use of opioids

6C43.Z Disorder due to use of opioids, unspecified

6C44 Disorders due to use of sedatives, hypnotics or anxiolytics

6C44.0 Episode of harmful use of sedatives, hypnotics or anxiolytics

6C44.1 Harmful pattern of use of sedatives, hypnotics or anxiolytics
Specify pattern:
6C44.10 … episodic
6C44.11 … continuous
6C44.1Z … unspecified

6C44.2 Sedative, hypnotic or anxiolytic dependence
Specify pattern of substance use or remission:
6C44.20 … current use

6C44.21 … early full remission
6C44.22 … sustained partial remission
6C44.23 … sustained full remission
6C44.2Z … unspecified

6C44.3 Sedative, hypnotic or anxiolytic intoxication
Specify severity:
6C44.3&XS5W Sedative, hypnotic or anxiolytic intoxication, mild
6C44.3&XS0T Sedative, hypnotic or anxiolytic intoxication, moderate
6C44.3&XS25 Sedative, hypnotic or anxiolytic intoxication, severe

6C44.4 Sedative, hypnotic or anxiolytic withdrawal
Specify clinical presentation:
6C44.40 … uncomplicated
6C44.41 … with perceptual disturbances
6C44.42 … with seizures
6C44.43 … with perceptual disturbances and seizures
6C44.4Z … unspecified

6C44.5 Sedative, hypnotic or anxiolytic-induced delirium

6C44.6 Sedative, hypnotic or anxiolytic-induced psychotic disorder

6C44.70 Sedative, hypnotic or anxiolytic-induced mood disorder

Specify clinical presentation:
6C44.700 … with depressive symptoms
6C44.701 … with manic symptoms
6C44.702 … with mixed depressive and manic symptoms
6C44.70Z … unspecified

6C44.71 Sedative, hypnotic or anxiolytic-induced anxiety disorder

6C44.Y Other specified disorder due to use of sedatives, hypnotics or anxiolytics

6C44.Z Disorder due to use of sedatives, hypnotics or anxiolytics, unspecified

6C45 Disorders due to use of cocaine

6C45.0 Episode of harmful use of cocaine

6C45.1 Harmful pattern of use of cocaine
Specify pattern:
6C45.10 … episodic
6C45.11 … continuous
6C45.1Z … unspecified

6C45.2 Cocaine dependence
Specify pattern of substance use or remission:
6C45.20 … current use
6C45.21 … early full remission
6C45.22 … sustained partial remission
6C45.23 … sustained full remission
6C45.2Z … unspecified

6C45.3 Cocaine intoxication
Specify severity:
6C45.3&XS5W Cocaine intoxication, mild
6C45.3&XS0T Cocaine intoxication, moderate
6C45.3&XS25 Cocaine intoxication, severe

6C45.4 Cocaine withdrawal

6C45.5 Cocaine-induced delirium

6C45.6 Cocaine-induced psychotic disorder
Specify clinical presentation:
6C45.60 … with hallucinations
6C45.61 … with delusions
6C45.62 … with mixed psychotic symptoms
6C45.6Z … unspecified

6C45.70 Cocaine-induced mood disorder
Specify clinical presentation:
6C45.700 … with depressive symptoms
6C45.701 … with manic symptoms
6C45.702 … with mixed depressive and manic symptoms
6C45.70Z … unspecified

6C45.71 Cocaine-induced anxiety disorder

6C45.72 Cocaine-induced obsessive-compulsive or related disorder

6C45.73 Cocaine-induced impulse control disorder

6C45.Y Other specified disorder due to use of cocaine

6C45.Z Disorder due to use of cocaine, unspecified

6C46 Disorders due to use of stimulants, including amfetamines, methamfetamine and methcathinone

6C46.0 Episode of harmful use of stimulants, including amfetamines, methamfetamine and methcathinone

6C46.1 Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone
Specify pattern:
6C46.10 … episodic
6C46.11 … continuous
6C46.1Z … unspecified

6C46.2 Stimulant dependence, including amfetamines, methamfetamine and methcathinone
Specify pattern of substance use or remission:
6C46.20 … current use
6C46.21 … early full remission
6C46.22 … sustained partial remission
6C46.23 … sustained full remission
6C46.2Z … unspecified

6C46.3 Stimulant intoxication, including amfetamines, methamfetamine and methcathinone

Specify severity:

6C46.3&XS5W	Stimulant intoxication, including amfetamines, methamfetamine and methcathinone, mild
6C46.3&XS0T	Stimulant intoxication, including amfetamines, methamfetamine and methcathinone, moderate
6C46.3&XS25	Stimulant intoxication, including amfetamines, methamfetamine and methcathinone, severe

6C46.4 Stimulant withdrawal, including amfetamines, methamfetamine and methcathinone

6C46.5 Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone

6C46.6 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone

Specify clinical presentation:

6C46.60	… with hallucinations
6C46.61	… with delusions
6C46.62	… with mixed psychotic symptoms
6C46.6Z	… unspecified

6C46.70 Stimulant-induced mood disorder, including amfetamines, methamfetamine and methcathinone

Specify clinical presentation:

6C46.700	… with depressive symptoms
6C46.701	… with manic symptoms
6C46.702	… with mixed depressive and manic symptoms
6C46.70Z	… unspecified

6C46.71 Stimulant-induced anxiety disorder, including amfetamines, methamfetamine and methcathinone

6C46.72 Stimulant-induced obsessive-compulsive or related disorder, including amfetamines, methamfetamine and methcathinone

6C46.73 Stimulant-induced impulse control disorder, including amfetamines, methamfetamine and methcathinone

6C46.Y Other specified disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone

6C46.Z Disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone, unspecified

6C47 Disorders due to use of synthetic cathinones

6C47.0 Episode of harmful use of synthetic cathinones

6C47.1 Harmful pattern of use of synthetic cathinones

Specify pattern:

6C47.10	… episodic
6C47.11	… continuous
6C47.1Z	… unspecified

6C47.2 Synthetic cathinone dependence
Specify pattern of substance use or remission:
6C47.20 … current use
6C47.21 … early full remission
6C47.22 … sustained partial remission
6C47.23 … sustained full remission
6C47.2Z … unspecified

6C47.3 Synthetic cathinone intoxication
Specify severity:
6C47.3&XS5W Synthetic cathinone intoxication, mild
6C47.3&XS0T Synthetic cathinone intoxication, moderate
6C47.3&XS25 Synthetic cathinone intoxication, severe

6C47.4 Synthetic cathinone withdrawal

6C47.5 Synthetic cathinone-induced delirium

6C47.6 Synthetic cathinone-induced psychotic disorder
Specify clinical presentation:
6C47.60 … with hallucinations
6C47.61 … with delusions
6C47.62 … with mixed psychotic symptoms
6C47.6Z … unspecified

6C47.70 Synthetic cathinone-induced mood disorder
Specify clinical presentation:
6C47.700 … with depressive symptoms
6C47.701 … with manic symptoms
6C47.702 … with mixed depressive and manic symptoms
6C47.70Z … unspecified

6C47.71 Synthetic cathinone-induced anxiety disorder

6C47.72 Synthetic cathinone-induced obsessive-compulsive or related syndrome

6C47.73 Synthetic cathinone-induced impulse control disorder

6C47.Y Other specified disorder due to use of synthetic cathinones

6C47.Z Disorder due to use of synthetic cathinones, unspecified

6C48 Disorders due to use of caffeine

6C48.0 Episode of harmful use of caffeine

6C48.1 Harmful pattern of use of caffeine
Specify pattern:
6C48.10 … episodic
6C48.11 … continuous
6C48.1Z … unspecified

6C48.2 Caffeine intoxication
Specify severity:
6C48.2&XS5W Caffeine intoxication, mild
6C48.2&XS0T Caffeine intoxication, moderate
6C48.2&XS25 Caffeine intoxication, severe

6C48.3 Caffeine withdrawal

6C48.71 Caffeine-induced anxiety disorder

6C48.Y Other specified disorder due to use of caffeine

6C48.Z Disorder due to use of caffeine, unspecified

6C49 Disorders due to use of hallucinogens

6C49.0 Episode of harmful use of hallucinogens

6C49.1 Harmful pattern of use of hallucinogens
Specify pattern:
6C49.10 … episodic
6C49.11 … continuous
6C49.1Z … unspecified

6C49.2 Hallucinogen dependence
Specify pattern of substance use or remission:
6C49.20 … current use
6C49.21 … early full remission
6C49.22 … sustained partial remission
6C49.23 … sustained full remission
6C49.2Z … unspecified

6C49.3 Hallucinogen intoxication
Specify severity:
6C49.3&XS5W Hallucinogen intoxication, mild
6C49.3&XS0T Hallucinogen intoxication, moderate
6C49.3&XS25 Hallucinogen intoxication, severe

6C49.4 Hallucinogen-induced delirium

6C49.5 Hallucinogen-induced psychotic disorder

6C49.60 Hallucinogen-induced mood disorder
Specify clinical presentation:
6C49.600 … with depressive symptoms
6C49.601 … with manic symptoms
6C49.602 … with mixed depressive and manic symptoms
6C49.60Z … unspecified

6C49.61 Hallucinogen-induced anxiety disorder

6C49.Y Other specified disorder due to use of hallucinogens

6C49.Z Disorder due to use of hallucinogens, unspecified

6C4A Disorders due to use of nicotine

6C4A.0 Episode of harmful use of nicotine

6C4A.1 Harmful pattern of use of nicotine
Specify pattern:
6C4A.10 … episodic
6C4A.11 … continuous
6C4A.1Z … unspecified

6C4A.2 Nicotine dependence
Specify pattern of substance use or remission:
6C4A.20 … current use
6C4A.21 … early full remission
6C4A.22 … sustained partial remission
6C4A.23 … sustained full remission
6C4A.2Z … unspecified

6C4A.3 Nicotine intoxication
Specify severity:
6C4A.3&XS5W Nicotine intoxication, mild
6C4A.3&XS0T Nicotine intoxication, moderate
6C4A.3&XS25 Nicotine intoxication, severe

6C4A.4 Nicotine withdrawal

6C4A.Y Other specified disorder due to use of nicotine

6C4A.Z Disorder due to use of nicotine, unspecified

6C4B Disorders due to use of volatile inhalants

6C4B.0 Episode of harmful use of volatile inhalants

6C4B.1 Harmful pattern of use of volatile inhalants
Specify pattern:
6C4B.10 … episodic
6C4B.11 … continuous
6C4B.1Z … unspecified

6C4B.2 Volatile inhalant dependence
Specify pattern of substance use or remission:
6C4B.20 … current use
6C4B.21 … early full remission
6C4B.22 … sustained partial remission
6C4B.23 … sustained full remission
6C4B.2Z … unspecified

6C4B.3 Volatile inhalant intoxication
Specify severity:
6C4B.3&XS5W Volatile inhalant intoxication, mild
6C4B.3&XS0T Volatile inhalant intoxication, moderate
6C4B.3&XS25 Volatile inhalant intoxication, severe

6C4B.4 Volatile inhalant withdrawal

6C4B.5 Volatile inhalant-induced delirium

6C4B.6 Volatile inhalant-induced psychotic disorder

6C4B.70 Volatile inhalant-induced mood disorder
Specify clinical presentation:
6C4B.700 … with depressive symptoms
6C4B.701 … with manic symptoms
6C4B.702 … with mixed depressive and manic symptoms
6C4B.70Z …unspecified

6C4B.71 Volatile inhalant-induced anxiety disorder

6C4B.Y Other specified disorder due to use of volatile inhalants

6C4B.Z Disorder due to use of volatile inhalants, unspecified

6C4C Disorders due to use of MDMA or related drugs, including MDA

6C4C.0 Episode of harmful use of MDMA or related drugs, including MDA

6C4C.1 Harmful pattern of use of MDMA or related drugs, including MDA
Specify pattern:
6C4C.10 … episodic
6C4C.11 … continuous
6C4C.1Z … unspecified

6C4C.2 MDMA or related drug dependence, including MDA
Specify pattern of substance use or remission:
6C4C.20 … current use
6C4C.21 … early full remission
6C4C.22 … sustained partial remission
6C4C.23 … sustained full remission
6C4C.2Z … unspecified

6C4C.3 MDMA or related drug intoxication, including MDA
Specify severity:
6C4C.3&XS5W MDMA or related drug intoxication, including MDA, mild
6C4C.3&XS0T MDMA or related drug intoxication, including MDA, moderate
6C4C.3&XS25 MDMA or related drug intoxication, including MDA, severe

6C4C.4 MDMA or related drug withdrawal, including MDA

6C4C.5 MDMA or related drug-induced delirium, including MDA

6C4C.6 MDMA or related drug-induced psychotic disorder, including MDA

6C4C.70 MDMA or related drug-induced mood disorder, including MDA
Specify clinical presentation:
6C4C.700 … with depressive symptoms
6C4C.701 … with manic symptoms
6C4C.702 … with mixed depressive and manic symptoms
6C4C.70Z … unspecified

6C4C.71 MDMA or related drug-induced anxiety disorder, including MDA

6C4C.Y Other specified disorder due to use of MDMA or related drugs, including MDA

6C4C.Z Disorder due to use of MDMA or related drugs, including MDA, unspecified

6C4D Disorders due to use of dissociative drugs, including ketamine and phencyclidine (PCP)

6C4D.0 Episode of harmful use of dissociative drugs, including ketamine and PCP

6C4D.1 Harmful pattern of use of dissociative drugs, including ketamine and PCP
Specify pattern:
6C4D.10 … episodic
6C4D.11 … continuous
6C4D.1Z … unspecified

6C4D.2 Dissociative drug dependence, including ketamine and PCP
Specify pattern of substance use or remission:
6C4D.20 … current use
6C4D.21 … early full remission
6C4D.22 … sustained partial remission
6C4D.23 … sustained full remission
6C4D.2Z … unspecified

6C4D.3 Dissociative drug intoxication, including ketamine and PCP
Specify severity:
6C4D.3&XS5W Dissociative drug intoxication, including ketamine and PCP, mild
6C4D.3&XS0T Dissociative drug intoxication, including ketamine and PCP, moderate
6C4D.3&XS25 Dissociative drug intoxication, including ketamine and PCP, severe

6C4D.4 Dissociative drug-induced delirium, including ketamine and PCP

6C4D.5 Dissociative drug-induced psychotic disorder, including ketamine and PCP

6C4D.60 Dissociative drug-induced mood disorder, including ketamine and PCP
Specify clinical presentation:
6C4D.600 … with depressive symptoms
6C4D.601 … with manic symptoms
6C4D.602 … with mixed depressive and manic symptoms
6C4D.60Z … unspecified

6C4D.61 Dissociative drug-induced anxiety disorder, including ketamine and PCP

6C4D.Y Other specified disorder due to use of dissociative drugs, including ketamine and PCP

6C4D.Z Disorder due to use of dissociative drugs, including ketamine and PCP, unspecified

6C4E Disorders due to use of other specified psychoactive substances, including medications

6C4E.0 Episode of harmful use of other specified psychoactive substance, including medications

6C4E.1 Harmful pattern of use of other specified psychoactive substance, including medications
Specify pattern:
6C4E.10 … episodic
6C4E.11 … continuous
6C4E.1Z … unspecified

6C4E.2 Other specified psychoactive substance dependence
Specify pattern of substance use or remission:
6C4E.20 … current use
6C4E.21 … early full remission
6C4E.22 … sustained partial remission
6C4E.23 … sustained full remission
6C4E.2Z … unspecified

6C4E.3 Other specified psychoactive substance intoxication
Specify severity:
6C4E.3&XS5W Other specified psychoactive substance intoxication, mild
6C4E.3&XS0T Other specified psychoactive substance intoxication, moderate
6C4E.3&XS25 Other specified psychoactive substance intoxication, severe

6C4E.4 Other specified psychoactive substance withdrawal
Specify clinical presentation:
6C4E.40 … uncomplicated
6C4E.41 … with perceptual disturbances
6C4E.42 … with seizures
6C4E.43 … with perceptual disturbances and seizures
6C4E.4Z … unspecified

6C4E.5 Delirium induced by other specified psychoactive substance, including medications

6C4E.6 Psychotic disorder induced by other specified psychoactive substance

6C4E.70 Mood disorder induced by other specified psychoactive substance
Specify clinical presentation:
6C4E.700 … with depressive symptoms
6C4E.701 … with manic symptoms
6C4E.702 … with mixed depressive and manic symptoms
6C4E.70Z … unspecified

6C4E.71 Anxiety disorder induced by other specified psychoactive substance

6C4E.72 Obsessive-compulsive or related disorder induced by other specified psychoactive substance

6C4E.73 Impulse control disorder induced by other specified psychoactive substance

6C4E.Y Other specified disorder due to use of other specified psychoactive substance, including medications

6C4E.Z Disorder due to use of other specified psychoactive substance, including medications, unspecified

6C4F Disorders due to use of multiple specified psychoactive substances, including medications

6C4F.0 Episode of harmful use of multiple specified psychoactive substances, including medications

6C4F.1 Harmful pattern of use of multiple specified psychoactive substances, including medications
Specify pattern:
6C4F.10 … episodic
6C4F.11 … continuous
6C4F.1Z … unspecified

6C4F.2 Multiple specified psychoactive substances dependence
Specify pattern of substance use or remission:
6C4F.20 … current use
6C4F.21 … early full remission

6C4F.22 … sustained partial remission
6C4F.23 … sustained full remission
6C4F.2Z … unspecified

6C4F.3 Intoxication due to multiple specified psychoactive substances
Specify severity:
6C4F.3&XS5W Intoxication due to multiple specified psychoactive substances, mild
6C4F.3&XS0T Intoxication due to multiple specified psychoactive substances, moderate
6C4F.3&XS25 Intoxication due to multiple specified psychoactive substances, severe

6C4F.4 Multiple specified psychoactive substances withdrawal
Specify clinical presentation:
6C4F.40 … uncomplicated
6C4F.41 … with perceptual disturbances
6C4F.42 … with seizures
6C4F.43 … with perceptual disturbances and seizures
6C4F.4Z … unspecified

6C4F.5 Delirium induced by multiple specified psychoactive substances, including medications

6C4F.6 Psychotic disorder induced by multiple specified psychoactive substances

6C4F.70 Mood disorder induced by multiple specified psychoactive substances
Specify clinical presentation:
6C4F.700 … with depressive symptoms
6C4F.701 … with manic symptoms
6C4F.702 … with mixed depressive and manic symptoms
6C4F.70Z … unspecified

6C4F.71 Anxiety disorder induced by multiple specified psychoactive substances

6C4F.72 Obsessive-compulsive or related disorder induced by multiple specified psychoactive substances

6C4F.73 Impulse control disorder induced by multiple specified psychoactive substances

6C4F.Y Other specified disorder due to use of multiple specified psychoactive substances, including medications

6C4F.Z Disorder due to use of multiple specified psychoactive substances, including medications, unspecified

6C4G Disorders due to use of unknown or unspecified psychoactive substances

6C4G.0 Episode of harmful use of unknown or unspecified psychoactive substance

6C4G.1 Harmful pattern of use of unknown or unspecified psychoactive substance
Specify pattern:
6C4G.10 … episodic
6C4G.11 … continuous
6C4G.1Z … unspecified

6C4G.2 Unknown or unspecified psychoactive substance dependence
Specify pattern of substance use or remission:
6C4G.20 … current use
6C4G.21 … early full remission
6C4G.22 … sustained partial remission
6C4G.23 … sustained full remission
6C4G.2Z … unspecified

6C4G.3 Intoxication due to unknown or unspecified psychoactive substance
Specify severity:
6C4G.3&XS5W Intoxication due to unknown or unspecified psychoactive substance, mild
6C4G.3&XS0T Intoxication due to unknown or unspecified psychoactive substance, moderate
6C4G.3&XS25 Intoxication due to unknown or unspecified psychoactive substance, severe

6C4G.4 Withdrawal due to unknown or unspecified psychoactive substance
Specify clinical presentation:
6C4G.40 … uncomplicated
6C4G.41 … with perceptual disturbances
6C4G.42 … with seizures
6C4G.43 … with perceptual disturbances and seizures
6C4G.4Z … unspecified

6C4G.5 Delirium induced by unknown or unspecified psychoactive substance

6C4G.6 Psychotic disorder induced by unknown or unspecified psychoactive substance

6C4G.70 Mood disorder induced by unknown or unspecified psychoactive substance
Specify clinical presentation:
6C4G.700 … with depressive symptoms
6C4G.701 … with manic symptoms
6C4G.702 … with mixed depressive and manic symptoms
6C4G.70Z … unspecified

6C4G.71 Anxiety disorder induced by unknown or unspecified psychoactive substance

6C4G.72 Obsessive-compulsive or related disorder induced by unknown or unspecified psychoactive substance

6C4G.73 Impulse control disorder induced by unknown or unspecified psychoactive substance

6C4G.Y Other specified disorder due to use of unknown or unspecified psychoactive substance

6C4G.Z Disorder due to use of unknown or unspecified psychoactive substance, unspecified

6C4H Disorders due to use of non-psychoactive substances

6C4H.0 Episode of harmful use of non-psychoactive substance

6C4H.1 Harmful pattern of use of non-psychoactive substance
Specify pattern:
6C4H.10 … episodic
6C4H.11 … continuous
6C4H.1Z … unspecified

6C4H.Z Disorder due to use of non-psychoactive substances, unspecified

6C4Z Disorder due to substance use, unspecified

Disorders due to addictive behaviours

6C50 Gambling disorder

Specify context:
6C50.0 … predominantly offline
6C50.1 … predominantly online
6C50.Z … unspecified

6C51 Gaming disorder

Specify context:
6C51.0 … predominantly online
6C51.1 … predominantly offline
6C51.Z … unspecified

6C5Y Other specified disorder due to addictive behaviours

6C5Z Disorder due to addictive behaviours, unspecified

Impulse control disorders

6C70 Pyromania

6C71 Kleptomania

6C72 Compulsive sexual behaviour disorder

6C73 Intermittent explosive disorder

6C7Y Other specified impulse control disorder

6C7Z Impulse control disorder, unspecified

Secondary-parented categories

From obsessive-compulsive and related disorders:

6B25 Body-focused repetitive behaviour disorders

6B25.0 Trichotillomania (hair-pulling disorder)
6B25.1 Excoriation (skin-picking) disorder
6B25.Y Other specified body-focused repetitive behaviour disorder
6B25.Z Body-focused repetitive behaviour disorder, unspecified

From disorders due to addictive behaviours:

6C50 Gambling disorder

Specify predominantly online or offline:

6C50.0 … predominantly offline
6C50.1 … predominantly online
6C50.Z … unspecified

6C51 Gaming disorder

Specify predominantly online or offline:
6C51.0 … predominantly online
6C51.1 … predominantly offline
6C51.Z … unspecified

From disorders due to substance use:

Substance-induced impulse control disorders

Specify substance class:

6C45.73	Cocaine-induced impulse control disorder
6C46.73	Stimulant-induced impulse control disorder, including amfetamines, methamfetamine and methcathinone
6C47.73	Synthetic cathinone-induced impulse control disorder
6C4E.73	Impulse control disorder induced by other specified psychoactive substance
6C4F.73	Impulse control disorder induced by multiple specified psychoactive substances
6C4G.73	Impulse control disorder induced by unknown or unspecified psychoactive substances

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E66 Secondary impulse control syndrome

Disruptive behaviour and dissocial disorders

6C90 Oppositional defiant disorder

Specify whether chronic irritability-anger is present:

6C90.0 Oppositional defiant disorder, with chronic irritability-anger
Specify limited or typical prosocial emotions:
6C90.00 … with limited prosocial emotions
6C90.01 … with typical prosocial emotions
6C90.0Z … unspecified

6C90.1 Oppositional defiant disorder, without chronic irritability-anger
Specify limited or typical prosocial emotions:
6C90.10 … with limited prosocial emotions
6C90.11 … with typical prosocial emotions
6C90.1Z … unspecified

6C90.Z Oppositional defiant disorder, unspecified

6C91 Conduct-dissocial disorder

Specify age of onset:

6C91.0 Conduct-dissocial disorder, childhood onset
Specify limited or typical prosocial emotions:
6C91.00 … childhood onset with limited prosocial emotions
6C91.01 … childhood onset with typical prosocial emotions
6C91.0Z … childhood onset, unspecified

6C91.1 Conduct-dissocial disorder, adolescent onset
6C91.10 … adolescent onset with limited prosocial emotions
6C91.11 … adolescent onset with typical prosocial emotions
6C91.1Z … adolescent onset, unspecified

6C91.Z Conduct-dissocial disorder, unspecified

6C9Y Other specified disruptive behaviour or dissocial disorder

6C9Z Disruptive behaviour or dissocial disorder, unspecified

Personality disorders and related traits

6D10 Personality disorder

Specify severity:

6D10.0 Mild personality disorder

6D10.1 Moderate personality disorder

6D10.2 Severe personality disorder

6D10.Z Personality disorder, severity unspecified

Postcoordination for personality disorders

For all above personality disorder categories, *specify* prominent personality traits or patterns using additional code(s):

6D11.0 Negative affectivity
6D11.1 Detachment
6D11.2 Dissociality
6D11.3 Disinhibition
6D11.4 Anankastia
6D11.5 Borderline pattern

Secondary-parented categories

From Chapter 21 on factors influencing health status or contact with health services

QE50.7 Personality difficulty

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E68 Secondary personality change

Paraphilic disorders

6D30	Exhibitionistic disorder
6D31	Voyeuristic disorder
6D32	Paedophilic disorder
6D33	Coercive sexual sadism disorder
6D34	Frotteuristic disorder
6D35	Other paraphilic disorder involving non-consenting individuals
6D36	Paraphilic disorder involving solitary behaviour or consenting individuals
6D3Z	Paraphilic disorder, unspecified

Factitious disorders

6D50	Factitious disorder imposed on self
6D51	Factitious disorder imposed on another
6D5Z	Factitious disorder, unspecified

Neurocognitive disorders

6D70 Delirium

Specify identified cause:

6D70.0 Delirium due to disease classified elsewhere

6D70.1 Delirium due to psychoactive substances, including medications

Specify substance class:
(***Note:*** the categories below are from the disorders due to substance use grouping.)

- 6C40.5 Alcohol-induced delirium
- 6C41.5 Cannabis-induced delirium
- 6C42.5 Synthetic cannabinoid-induced delirium
- 6C43.5 Opioid-induced delirium
- 6C44.5 Sedative, hypnotic or anxiolytic-induced delirium
- 6C45.5 Cocaine-induced delirium
- 6C46.5 Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone
- 6C47.5 Synthetic cathinone-induced delirium
- 6C49.4 Hallucinogen-induced delirium
- 6C4B.5 Volatile inhalant-induced delirium
- 6C4C.5 MDMA or related drug-induced delirium, including MDA
- 6C4D.4 Dissociative drug-induced delirium, including ketamine and PCP
- 6C4E.5 Delirium induced by other specified psychoactive substance, including medications
- 6C4F.5 Delirium induced by multiple specified psychoactive substances, including medications
- 6C4G.5 Delirium induced by unknown or unspecified psychoactive substances

6D70.2 Delirium due to multiple etiological factors

6D70.Y Delirium, other specified cause

6D70.Z Delirium, unknown or unspecified cause

6D71 Mild neurocognitive disorder

6D72 Amnestic disorder

Specify identified cause:

6D72.0 Amnestic disorder due to diseases classified elsewhere

6D72.1 Amnestic disorder due to psychoactive substances, including medications

Specify substance class:

- **6D72.10** Amnestic disorder due to use of alcohol
- **6D72.11** Amnestic disorder due to use of sedatives, hypnotics or anxiolytics

6D72.12 Amnestic disorder due to other specific psychoactive substance, including medications
6D72.13 Amnestic disorder due to use of volatile inhalants
6D72.Y Amnestic disorder, other specified cause
6D72.Z Amnestic disorder, unknown or unspecified cause

Dementia

Specify identified causal condition:

6D80 Dementia due to Alzheimer disease

Specify subtype of Alzheimer disease:
6D80.0 … with early onset
6D80.1 … with late onset
6D80.2 … mixed type, with cerebrovascular disease
6D80.3 … mixed type, with other nonvascular etiologies
6D80.Z … onset unknown or unspecified

6D81 Dementia due to cerebrovascular disease

6D82 Dementia due to Lewy body disease

6D83 Frontotemporal dementia

6D84 Dementia due to psychoactive substances, including medications

Specify substance class:
6D84.0 Dementia due to use of alcohol
6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics
6D84.2 Dementia due to use of volatile inhalants
6D84.Y Dementia due to other specified psychoactive substance

6D85 Dementia due to diseases classified elsewhere

Specify identified causal condition:

6D85.0	Dementia due to Parkinson disease
6D85.1	Dementia due to Huntington disease
6D85.2	Dementia due to exposure to heavy metals and other toxins
6D85.3	Dementia due to HIV
6D85.4	Dementia due to multiple sclerosis
6D85.5	Dementia due to prion disease
6D85.6	Dementia due to normal-pressure hydrocephalus
6D85.7	Dementia due to injury to the head
6D85.8	Dementia due to pellagra
6D85.9	Dementia due to Down syndrome
6D85.Y	Dementia due to other specified disease classified elsewhere

6D8Y Dementia, other specified cause

6D8Z Dementia, unknown or unspecified cause

Postcoordination for dementia:

For all above dementia categories, specify severity of dementia by using additional code:

XS5W	Mild
XS0T	Moderate
XS25	Severe

For all above dementia categories, *specify* behavioural or psychological disturbances in dementia by using additional code(s) if applicable:

6D86.0	Psychotic symptoms in dementia
6D86.1	Mood symptoms in dementia
6D86.2	Anxiety symptoms in dementia
6D86.3	Apathy in dementia
6D86.4	Agitation or aggression in dementia
6D86.5	Disinhibition in dementia
6D86.6	Wandering in dementia
6D86.Y	Other specified behavioural or psychological disturbance in dementia
6D86.Z	Behavioural or psychological disturbances in dementia, unspecified

6E0Y	Other specified neurocognitive disorder
6E0Z	Neurocognitive disorder, unspecified

Secondary-parented category

From secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere:

6E67	Secondary neurocognitive syndrome

Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium

6E20	Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms
6E21	Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms
6E2Z	Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

Psychological or behavioural factors affecting disorders and diseases classified elsewhere

6E40.0	Mental disorder affecting disorders and diseases classified elsewhere

6E40.1 Psychological symptoms affecting disorders and diseases classified elsewhere

6E40.2 Personality traits or coping style affecting disorders and diseases classified elsewhere

6E40.3 Maladaptive health behaviours affecting disorders and diseases classified elsewhere

6E40.4 Stress-related physiological response affecting disorders and diseases classified elsewhere

6E40.Y Other specified psychological or behavioural factor affecting disorders and diseases classified elsewhere

6E40.Z Psychological or behavioural factors affecting disorders and diseases classified elsewhere, unspecified

Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere

6E60 Secondary neurodevelopmental syndrome

6E60.0 Secondary speech or language syndrome
6E60.Y Other specified secondary neurodevelopmental syndrome
6E60.Z Secondary neurodevelopmental syndrome, unspecified

6E61 Secondary psychotic syndrome

Specify clinical presentation:
6E61.0 … with hallucinations
6E61.1 … with delusions
6E61.2 … with hallucinations and delusions
6E61.3 … with unspecified symptoms

6E62 Secondary mood syndrome

Specify clinical presentation:

6E62.0 … with depressive symptoms
6E62.1 … with manic symptoms
6E62.2 … with mixed symptoms
6E62.3 … with unspecified symptoms

6E63 Secondary anxiety syndrome

6E64 Secondary obsessive-compulsive or related syndrome

6E65 Secondary dissociative syndrome

6E66 Secondary impulse control syndrome

6E67 Secondary neurocognitive syndrome

6E68 Secondary personality change

6E69 Secondary catatonia syndrome

6E6Y Other specified secondary mental or behavioural syndrome

6E6Z Secondary mental or behavioural syndrome, unspecified

Mental, behavioural and neurodevelopmental disorders

Mental, behavioural and neurodevelopmental disorders are syndromes characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behaviour that reflects a dysfunction in the psychological, biological or developmental processes that underlie mental and behavioural functioning. These disturbances are usually associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Neurodevelopmental disorders

Neurodevelopmental disorders are behavioural and cognitive disorders arising during the developmental period that involve significant difficulties in the acquisition and execution of specific intellectual, motor, language or social functions. In this context, arising during the developmental period is typically considered to mean that these disorders have their onset prior to 18 years of age, regardless of the age at which the individual first comes to clinical attention. Although behavioural and cognitive deficits are present in many mental and behavioural disorders that can arise during the developmental period (e.g. schizophrenia, bipolar disorder), only disorders whose core features are neurodevelopmental are included in this grouping. The presumptive etiology for neurodevelopmental disorders is complex, and in many individual cases is unknown, but they are presumed to be primarily due to genetic or other factors that are present from birth. However, lack of appropriate environmental stimulation and lack of adequate learning opportunities and experiences may also be contributory factors in neurodevelopmental disorders and should be considered routinely in their assessment. Certain neurodevelopmental disorders may also arise from injury, disease or other insult to the central nervous system, when this occurs during the developmental period.

Neurodevelopmental disorders include the following:

6A00 Disorders of intellectual development

6A01 Developmental speech and language disorders
- 6A01.0 Developmental speech sound disorder
- 6A01.1 Developmental speech fluency disorder
- 6A01.2 Developmental language disorder
- 6A01.Y Other specified developmental speech or language disorder
- 6A01.Z Developmental speech or language disorder, unspecified

6A02 Autism spectrum disorder

6A03 Developmental learning disorder

6A04 Developmental motor coordination disorder

6A05 Attention deficit hyperactivity disorder

6A06 Stereotyped movement disorder

6A0Y Other specified neurodevelopmental disorder

6A0Z Neurodevelopmental disorder, unspecified.

In addition, three categories from the grouping of primary tics and tic disorders in Chapter 8 on diseases of the nervous system are cross-listed here, with diagnostic guidance provided, because of their high co-occurrence and familial association with neurodevelopmental disorders. These include:

8A05.00	Tourette syndrome
8A05.01	Chronic motor tic disorder
8A05.02	Chronic phonic tic disorder

General cultural considerations for neurodevelopmental disorders

- The evaluation of the essential features of most of the disorders in this section either depends on or is informed by standardized assessments. The cultural appropriateness of tests and norms used to assess intellectual, motor, language or social abilities should be considered for each individual. Test performance may be affected by cultural biases (e.g. reference in test items to terminology or objects not common to a culture) and limitations of translation. Language proficiency must also be considered when interpreting test results. Where appropriately normed and standardized tests are not available, assessment of the essential features of these disorders requires greater reliance on clinical judgement based on appropriate evidence and assessment.

6A00 Disorders of intellectual development

Essential (required) features

- The presence of significant limitations in intellectual functioning across various domains such as perceptual reasoning, working memory, processing speed and verbal comprehension is required for diagnosis. There is often substantial variability in the extent to which any of these domains are affected in an individual. Whenever possible, performance should be measured using appropriately normed, standardized tests of intellectual functioning and found to be approximately 2 or more standard deviations below the mean (i.e. approximately less than the 2.3rd percentile). In situations where appropriately normed and standardized tests are not available, assessment of intellectual functioning requires greater reliance on clinical judgement based on appropriate evidence and assessment, which may include the use of behavioural indicators of intellectual functioning (see Table 6.1, p. 101).
- The presence of significant limitations in adaptive behaviour, which refers to the set of *conceptual*, *social* and *practical skills* that have been learned and are performed by people in their everyday lives, is an essential component. *Conceptual skills* are those that involve the application of knowledge (e.g. reading, writing, calculating, solving problems and making decisions) and communication; *social skills* include managing interpersonal interactions

and relationships, social responsibility, following rules and obeying laws, and avoiding victimization; and *practical skills* are involved in areas such as self-care, health and safety, occupational skills, recreation, use of money, mobility and transportation, as well as use of home appliances and technological devices. Expectations of adaptive functioning may change in response to environmental demands that change with age. Whenever possible, performance should be measured with appropriately normed, standardized tests of adaptive behaviour and the total score found to be approximately 2 or more standard deviations below the mean (i.e. approximately less than the 2.3rd percentile). In situations where appropriately normed and standardized tests are not available, assessment of adaptive behaviour functioning requires greater reliance on clinical judgement based on appropriate assessment, which may include the use of behavioural indicators of adaptive behaviour skills (see Tables 6.2–6.4, pp. 104–111).

- Onset occurs during the developmental period. Among adults with disorders of intellectual development who come to clinical attention without a previous diagnosis, it is possible to establish developmental onset through the person's history (retrospective diagnosis).

Severity specifiers

The severity of a disorder of intellectual development is determined by considering both the individual's level of intellectual ability and level of adaptive behaviour, ideally assessed using appropriately normed, individually administered standardized tests. Where appropriately normed and standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement based on appropriate evidence and assessment, which may include the use of behavioural indicators of intellectual and adaptive functioning provided in Tables 6.1–6.4.

Generally, the level of severity should be assigned on the basis of the level at which the majority of the individual's intellectual ability and adaptive behaviour skills across all three domains – conceptual, social and practical skills – fall. For example, if intellectual functioning and two of three adaptive behaviour domains are determined to be 3–4 standard deviations below the mean, moderate disorder of intellectual development would be the most appropriate diagnosis. However, this formulation may vary according to the nature and purpose of the assessment, as well as the importance of the behaviour in question in relation to the individual's overall functioning.

6A00.0 Disorder of intellectual development, mild

- In mild disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 2–3 standard deviations below the mean (approximately 0.1–2.3 percentile), based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People with mild disorder of intellectual development often exhibit difficulties in the acquisition and comprehension of complex language concepts and academic skills. Most master basic self-care, domestic and practical activities. Affected people can generally achieve relatively independent living and employment as adults, but may require appropriate support.

6A00.1 Disorder of intellectual development, moderate

- In moderate disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 3–4 standard deviations below the mean (approximately 0.003–0.1 percentile), based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. Language and capacity for acquisition of academic skills of people affected by moderate disorder of intellectual development vary but are generally limited to basic skills. Some may master basic self-care, domestic and practical activities. Most affected people require considerable and consistent support in order to achieve independent living and employment as adults.

6A00.2 Disorder of intellectual development, severe

- In severe disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 4 or more standard deviations below the mean (less than approximately the 0.003rd percentile), based on appropriately normed, individually administered standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People affected by severe disorder of intellectual development exhibit very limited language and capacity for acquisition of academic skills. They may also have motor impairments and typically require daily support in a supervised environment for adequate care, but may acquire basic self-care skills with intensive training. Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

6A00.3 Disorder of intellectual development, profound

- In profound disorder of intellectual development, intellectual functioning and adaptive behaviour are found to be approximately 4 or more standard deviations below the mean (approximately less than the 0.003rd percentile), based on individually administered appropriately normed, standardized tests. Where standardized tests are not available, assessment of intellectual functioning and adaptive behaviour requires greater reliance on clinical judgement, which may include the use of behavioural indicators provided in Tables 6.1–6.4. People affected by profound disorder of intellectual development possess very limited communication abilities and capacity for acquisition of academic skills is restricted to basic concrete skills. They may also have co-occurring motor and sensory impairments and typically require daily support in a supervised environment for adequate care. Severe and profound disorders of intellectual development are differentiated exclusively on the basis of adaptive behaviour differences because existing standardized tests of intelligence cannot reliably or validly distinguish among individuals with intellectual functioning below the 0.003rd percentile.

6A00.4 Disorder of intellectual development, provisional

- Provisional disorder of intellectual development is assigned when there is evidence of a disorder of intellectual development but the individual is an infant or child under the age of 4 years, making it difficult to ascertain whether the observed impairments represent a transient delay. Provisional disorder of intellectual development in this context is sometimes referred to as "global developmental delay". The diagnosis can also be assigned in individuals 4 years of age or older when evidence is suggestive of a disorder of intellectual development but it is not possible to conduct a valid assessment of intellectual functioning and adaptive behaviour because of sensory or physical impairments (e.g. blindness, pre-lingual deafness), motor or communication impairments, severe problem behaviours, or symptoms of another mental, behavioural or neurodevelopmental disorder that interfere with assessment.

6A00.Z Disorder of intellectual development, unspecified

Additional clinical features

- No single physical feature or personality type is common to all individuals with disorders of intellectual development, although specific etiological groups may have common physical characteristics.
- Disorders of intellectual development are associated with a high rate of co-occurring mental, behavioural and neurodevelopmental disorders. However, clinical presentations may vary depending on the individual's age, level of severity of the disorder of intellectual development, communication skills and symptom complexity. Some disorders – such as autism spectrum disorder, depressive disorders, bipolar and related disorders, schizophrenia, dementia and attention deficit hyperactivity disorder – occur more commonly among individuals with disorders of intellectual development than in the general population. Individuals with a co-occurring disorder of intellectual development and other mental, behavioural and neurodevelopmental disorders are at similar risk of suicide as individuals with mental disorders who do not have a co-occurring disorder of intellectual development.
- Problem or challenging behaviours such as aggression, self-injurious behaviour, attention-seeking behaviour, oppositional defiant behaviour and sexually inappropriate behaviour are more frequent among those with disorders of intellectual development than in the general population.
- Many individuals with disorders of intellectual development are more gullible and naive, easier to deceive, and more prone to acquiescence and confabulation than people in the general population. This can lead to various consequences, including greater likelihood of victimization, becoming involved in criminal activities and providing inaccurate statements to law enforcement.
- Significant life changes and traumatic experiences can be particularly difficult for a person with a disorder of intellectual development. Whereas the timing and type of life transitions vary across societies, it is generally the case that individuals with disorders of intellectual

development need additional support adapting to changes in routine, structure, or educational or living arrangements.

- Many medical conditions can cause disorders of intellectual development and are, in turn, associated with specific additional medical problems. A variety of prenatal (e.g. exposure to toxic substances or harmful medications), perinatal (e.g. labour and delivery problems) and postnatal (e.g. infectious encephalopathies) factors may contribute to the development of disorders of intellectual development, and multiple etiologies may interact. Early diagnosis of the etiology of a disorder of intellectual development, when possible, can assist in the prevention and management of related medical problems (e.g. frequent thyroid disease screening is recommended for individuals with Down syndrome). If the etiology of a disorder of intellectual development in a particular individual has been established, the diagnosis corresponding to that etiology should also be assigned.
- Individuals with disorders of intellectual development are at greater risk of a variety of health (e.g. epilepsy) and social (e.g. poverty) problems across the lifespan.

Boundary with normality (threshold)

- In disorders of intellectual development, a measure of intelligence quotient (IQ) is not an isolated diagnostic requirement to distinguish disorder from normality, but should be considered a proxy measure of the "significant limitations in intellectual functioning" that partially characterize disorders of intellectual development. IQ scores may vary as a result of the technical properties of the specific test being used, the testing conditions and a variety of other variables, and also can vary substantially over the individual's development and life-course. The diagnosis of disorders of intellectual development should not be made solely based on IQ scores but must also include a comprehensive evaluation of adaptive behaviour.
- Scores on individually administered standardized tests of intellectual and adaptive functioning may vary considerably over the course of an individual's development, and it is quite possible that, during the developmental period, a child may meet the diagnostic requirements of disorders of intellectual development on one occasion but not another. Multiple testing on different occasions during the developmental trajectory is necessary to establish a reliable estimate of functioning.
- Special care should be taken in differentiating disorders of intellectual development from normality when evaluating people with communication, sensory or motor impairments; those exhibiting behavioural disturbances; immigrants; people with low literacy levels; people with mental disorders; people undergoing medical treatments (e.g. pharmacotherapy); and people who have experienced severe social or sensory deprivation. If not adequately addressed during the evaluation, these factors may reduce the validity of scores obtained on standardized or behavioural measures of intellectual and adaptive functioning. For example, the reliable use of standardized measures of intellectual functioning and adaptive behaviour may pose particular challenges among individuals with motor coordination and communication impairments, and assessments must be selected that are appropriate to the individual's capacities.
- What is sometimes termed "borderline intellectual functioning", defined as intellectual functioning between approximately 1 and 2 standard deviations below the mean, is not a diagnosable disorder. Nonetheless, such individuals may present many needs for support and interventions that are similar to those of people with disorders of intellectual development.

Course features

- Disorders of intellectual development are lifespan conditions that typically manifest during early childhood and require consideration of developmental phases and life transitions whereby periods of relatively greater need may alternate with those where less support may be necessary.
- Disorders of intellectual development may show individual as well as etiology-specific variation in developmental trajectories (i.e. periods of relative decline or amelioration in functioning). Intellectual functioning and adaptive behaviour can vary substantially across the lifespan. Results from a single assessment, particularly those obtained during early childhood, may be of limited predictive use, as later functioning will be influenced by the level and type of interventions and support provided.
- People with disorders of intellectual development typically need exceptional support throughout the lifespan, although the types and intensities of required support often change over time depending on age, development, environmental factors and life circumstances. Most people with disorders of intellectual development continue to acquire skills and competencies over time. Providing interventions and support – including education – assists with this process and, if provided during the developmental period, may result in lower support needs in adulthood.

Developmental presentations

- There is wide variability in the developmental presentation and developmental trajectories of individuals with disorders of intellectual development. Tables 6.2–6.4 provide clinicians with some of the key areas of strengths and weaknesses typically observed at different time points across development (i.e. early childhood, childhood, adolescence and adulthood) in individuals with disorders of intellectual development.
- Conditions related to disorders of intellectual development may be suspected during the first days and months of life due to the presence of certain physical signs such as facial dimorphisms, congenital malformation, micro- or macrocephalia, low weight, hypotonia, physical growth retardation, metabolic problems and failure to thrive, among others.
- In older children, disorders of intellectual development may manifest as problems in acquiring academic knowledge and abilities such as reading, writing and arithmetic. Many children with mild disorder of intellectual development may not be referred for evaluation until they reach school age. Some individuals may remain undiagnosed until much later, during adolescence or adulthood.
- The manifestations of disorders of intellectual development during late adolescence and the first years of adulthood may be strongly influenced by the presence of challenges related to assuming adult roles, such as postsecondary education, employment, independent living and adult relationships.
- Older adults with disorders of intellectual development may present with a more rapid onset of dementia or declining skills than older adults in the general population. They also have significantly more difficulty gaining access to necessary support and appropriate health care for medical problems.

Culture-related features

- The cultural appropriateness of tests and norms used to assess intellectual and adaptive functioning should be considered for each individual. Test performance may be affected by cultural biases (e.g. reference in test items to terminology or objects not common to a culture) and limitations of translation.
- In evaluating adaptive functioning (i.e. the individual's *conceptual*, *social* and *practical* skills), the expectations of the individual's culture and social environment should be considered.
- Language proficiency must also be considered when interpreting test results, in terms of both its impact on verbal performance and whether the individual understood the instructions.

Sex- and/or gender-related features

- The overall prevalence of disorders of intellectual development is slightly higher in males. The prevalence of some etiologies of disorders of intellectual development differs between males and females (e.g. X-linked genetic conditions such as fragile X syndrome are predominantly diagnosed in males, whereas Turner syndrome occurs exclusively in females).
- A number of associated features of disorders of intellectual development differ between males and females – for example, in the expression of problem behaviours and co-occurring mental, behavioural and neurodevelopmental disorders. Males are more likely to exhibit hyperactivity and conduct disturbances, whereas females are more likely to exhibit mood and anxiety symptoms.
- Reduced social value and expectations placed on females compared to males in some societies may negatively affect the accurate identification and provision of support for females with disorders of intellectual development.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with developmental speech and language disorders

In developmental speech and language disorders, individuals exhibit difficulties in understanding or producing speech and language, or in using language in context for the purposes of communication that is markedly below what would be expected given the individual's age and level of intellectual functioning. If speech and language abilities are significantly below what would be expected based on intellectual and adaptive behaviour functioning in an individual with a disorder of intellectual development, an additional diagnosis of developmental speech and language disorder may be assigned.

Boundary with autism spectrum disorder

Autism spectrum disorder is characterized by persistent deficits in reciprocal social interaction and social communication, and by a range of restricted, repetitive, inflexible patterns of behaviour and interests. Although many individuals with autism spectrum disorder present with the significant limitations in intellectual functioning and adaptive behaviour observed in disorders of intellectual development, autism spectrum disorder can also present without general limitations in intellectual functioning. In cases of autism spectrum disorder where there are significant limitations in intellectual functioning and adaptive behaviour (i.e. 2 or more standard deviations below the mean or approximately less than the 2.3rd percentile) both the diagnosis of autism spectrum disorder using the *with disorder of intellectual development* specifier and the diagnosis of a disorder of intellectual development at the corresponding level of severity should be assigned. The diagnosis of autism spectrum disorder in individuals with severe and profound disorders of intellectual development is particularly difficult, and requires in-depth and longitudinal assessments. Because autism spectrum disorder inherently involves social deficits, assessment of adaptive behaviour as a part of the diagnosis of a co-occurring disorder of intellectual development should place greater emphasis on the conceptual and practical domains of adaptive functioning than on social skills.

Boundary with developmental learning disorders

Developmental learning disorders are characterized by significant and persistent difficulties in learning academic skills including reading, writing and arithmetic, with performance in these areas markedly below what would be expected based on chronological age or intellectual level. Individuals with disorders of intellectual development often present with limitations in academic achievement by virtue of significant generalized deficits in intellectual functioning. It is therefore difficult to establish the co-occurring presence of a developmental learning disorder in individuals with a disorder of intellectual development. However, developmental learning disorders can co-occur in some individuals with disorders of intellectual development if, despite adequate opportunities, acquisition of learning is significantly below what is expected based on established intellectual functioning. In such cases, both disorders may be diagnosed.

Boundary with developmental motor coordination disorders

In developmental motor coordination disorder, individuals exhibit significant delays during the developmental period in the acquisition of gross and fine motor skills, and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness or inaccuracy of motor performance. Individuals with disorders of intellectual development may also display such motor coordination difficulties that affect adaptive behaviour functioning. In contrast to those with developmental motor coordination disorder, individuals with disorders of intellectual development have accompanying significant limitations in intellectual functioning. However, if coordinated motor skills are significantly below what would be expected based on level of intellectual functioning and adaptive behaviour, and represent a separate focus of clinical attention, both diagnoses may be assigned.

Boundary with attention deficit hyperactivity disorder

In attention deficit hyperactivity disorder, individuals show a persistent and generalized pattern of inattention and/or hyperactivity-impulsivity that emerges during the developmental period. If all diagnostic requirements for a disorder of intellectual development are met, and inattention and/or hyperactivity-impulsivity are found to be outside normal expected limits based on age and level of intellectual functioning, with significant interference in academic, occupational or social functioning, both diagnoses may be assigned.

Boundary with dementia

In dementia, affected individuals – usually older adults – exhibit a decline from a previous level of functioning in multiple cognitive domains that interferes significantly with performance of

activities of daily living. The disorders can co-occur, and some adults with disorders of intellectual development are at greater and earlier risk of developing dementia. For example, individuals with Down syndrome who exhibit a marked decline in adaptive behaviour functioning should be evaluated for the emergence of dementia. In cases in which the diagnostic requirements for both a disorder of intellectual development and dementia are met and describe non-redundant aspects of the clinical presentation, both diagnoses may be assigned.

Boundary with other mental and behavioural disorders

Other mental and behavioural disorders such as schizophrenia and other primary psychotic disorders may include symptoms that interfere with intellectual functioning and adaptive behaviour. A disorder of intellectual development should not be diagnosed if the limitations are better accounted for by another mental and behavioural disorder. However, other mental and behavioural disorders are at least as prevalent in individuals with disorders of intellectual development as in the general population, and co-occurring diagnoses should be assigned if warranted. In evaluating mental and behavioural disorders in individuals with disorders of intellectual development, signs and symptoms must be assessed using methods that are appropriate to the individual's level of development and intellectual functioning, and may require a greater reliance on observable signs and the reports of others who are familiar with the individual.

Boundary with sensory impairments

If not addressed, sensory impairments (e.g. visual, auditory) can interfere with opportunities for learning, resulting in apparent limitations in intellectual functioning or adaptive behaviour. If the observed limitations are solely attributable to a sensory impairment, a disorder of intellectual development should not be assigned. However, prolonged sensory impairment throughout the critical period of development may result in the persistence of limitations in intellectual functioning or adaptive behaviour, despite later intervention, and an additional diagnosis of a disorder of intellectual development may be warranted in such cases.

Boundary with effects of psychosocial deprivation

Extreme psychosocial deprivation in early childhood can produce severe and selective impairments in specific mental functions such as language, social interaction and emotional expression. Depending on the onset, level of severity and duration of the deprivation, functioning in these areas may improve substantially after the child is moved to a more positive environment. However, some deficits may persist even after a sustained period in an environment that provides adequate stimulation for development, and a diagnosis of a disorder of intellectual development may be appropriate in such cases if all diagnostic requirements are met.

Boundary with neurodegenerative diseases

Neurodegenerative diseases can be associated with disorders of intellectual development but only if they have their onset in the developmental period (e.g. mucolipidosis type I, Gaucher's disease type III). If a neurodegenerative disease co-occurs with a disorder of intellectual development, both diagnoses should be assigned.

Boundary with secondary neurodevelopmental syndrome

If the diagnostic requirements of a disorder of intellectual development are met and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, both disorder of intellectual development and the underlying medical conditions should be diagnosed. If the diagnostic requirements of a disorder of intellectual development are not met (e.g. limitations in intellectual functioning without limitations in adaptive functioning) and the symptoms are attributed to medical conditions with onset during the prenatal or developmental period, a diagnosis of secondary neurodevelopmental syndrome should be assigned, together with the diagnosis corresponding to the underlying medical condition.

Table 6.1. Behavioural indicators of intellectual functioning

Severity level	Early childhood	Childhood and adolescence	Adulthood
Mild	By the end of this developmental period, there is evidence of the emergence or presence of the abilities listed below. • Most will develop language skills and be able to communicate needs. Delays in the acquisition of language skills are typical, and once acquired the skills are frequently less developed than in typically developing peers (e.g. more limited vocabulary). • Most can tell or identify their gender and age. • Most can attend to a simple cause-effect relationship. • Most can attend to and follow up to 2-step instructions. • Most can make one-to-one correspondence or match to sample (e.g. organize or match items according to shape, size, colour). • Most can communicate their immediate future goals (e.g. desired activities for the day). • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress. **Literacy/numeracy** • Most will develop emergent reading and writing skills. • Most will be able to recognize letters from their name, and some can recognize their own name in print.	During this developmental period, there is evidence of the emergence or presence of the abilities listed below. • Most can communicate effectively. • Most can tell or identify their age. • Most can initiate/invite others to participate in an activity. • Most can communicate about past, present and future events. • Most can attend to and follow up to 3-step instructions. • Most can identify different denominations of money (e.g. coins) and count small amounts of money. • Most can cross street intersections safely (look in both directions, wait for traffic to clear before crossing, obey traffic signals). In contexts without busy intersections, most can follow socially acceptable rules necessary to ensure personal safety. • Most can communicate their future goals and participate in their health care. • Most can identify many of their relatives and their relationships. • Most can apply existing abilities in order to build skills for future semi-skilled employment (i.e. involving the performance of routine operations) and in some cases skilled employment (e.g. requiring some independent judgement and responsibility). • Most are naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. • Some can orient themselves in the community and travel to new places using familiar modes of transportation. **Literacy/numeracy** • Most can read sentences with five common words. • Most can count and make simple additions and subtractions.	• Most can communicate fluently. • Many can tell or identify their birth date. • Most can initiate/invite others to participate in an activity. • Most can communicate about past, present and future events. • Most can attend to and follow up to 3-step instructions. • Most can identify different denominations of money (e.g. coins) and count money more or less accurately. • Most can orient themselves in the community and learn to travel to new places using different modes of transportation with instruction/training. • Some can learn the road laws and meet requirements to obtain a driver's license. Travel is mainly restricted to familiar environments. • Most can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey traffic signals). In contexts without busy intersections, most can follow socially acceptable rules necessary to ensure personal safety. • Most can communicate their decisions about their future goals, health care and relationships (e.g. who they prefer to spend time with). • Most can apply existing abilities in the context of semi-skilled employment (i.e. involving the performance of routine operations) and in some cases skilled employment (e.g. requiring some independent judgement and responsibility). • Most remain naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. • Most have difficulty in handling complex situations such as managing bank accounts and long-term money management. **Literacy/numeracy** • Most can read and write up to approximately a level expected for someone who has attended 7–8 years of schooling (i.e. start of middle/secondary school), and read simple material for information and entertainment. • Most can count, understand mathematical concepts and make simple mathematical calculations.

Table 6.1. contd

Severity level	Early childhood	Childhood and adolescence	Adulthood
Moderate	• Most will develop language skills and be able to communicate needs. Delays in the acquisition of language skills are typical, and once acquired the skills are often less developed than in typically developing peers (e.g. more limited vocabulary). • Most can follow 1-step instructions. • Most can self-initiate activities and participate in parallel play. Some develop simple interactive play. • Some can attend to a simple cause-effect relationship. • Most can distinguish between "more" and "less". • Some can make one-to-one correspondence or match to sample (e.g. organize or match items according to shape, size, colour). • Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress. **Literacy/numeracy** • Most can recognize symbols.	• Most can tell or identify their age and gender. • Most can initiate/invite others to participate in an activity. • Most can communicate immediate experiences. • Most can attend to and follow up to 2-step instructions. • Some can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey lights and signal signals). In contexts without busy intersections, some can follow socially acceptable rules necessary to ensure personal safety. • Some can go independently to nearby familiar places. • Most can communicate preferences about their future goals when provided with options. • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress. • With support, most can apply existing abilities in order to build skills for future semi-skilled employment (i.e. involving the performance of routine operations). • Most are naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. **Literacy/numeracy** • Most will develop emergent reading and writing skills. • Most can recognize their own name in print. • Most can choose the correct number of objects. • Some can learn to count up to 10.	• Most can initiate/invite others to participate in an activity. • Most can communicate immediate experiences. • Most can attend to and follow up to 2-step instructions. • Most can cross residential street intersections safely (look in both directions, wait for traffic to clear before crossing, obey lights and signal signals). In contexts without busy intersections, some can follow socially acceptable rules necessary to ensure personal safety. • Some can travel independently to familiar places. • Most can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with), and will often act in accordance with these preferences. • Some can apply existing abilities in the context of semi-skilled employment (i.e. involving the performance of routine operations). • Most remain naive in anticipating full consequences of actions or recognizing when someone is trying to exploit them. **Literacy/numeracy** • Most can read sentences with three common words and can achieve a reading and writing level up to that expected of someone who has attended 4–5 years of schooling (i.e. several years of primary/elementary school). • Most can choose the correct number of objects. • Most can count to 10 and in some cases higher.
Severe	• Most will develop various simple nonverbal strategies to communicate basic needs. • Some can self-initiate activities. • Most can attend to and respond to others. • Most can separate one object from a group upon request. • Most can stop an activity upon request.	• Most can use communication strategies to indicate preferences. • Most can self-initiate activities. • Most can attend to and recognize familiar pictures. • Most can follow 1-step instructions and stop an activity upon request. • Most can distinguish between "more" and "less". • Most can separate one object from a group upon request.	• Most can use communication strategies to indicate preferences. • Most can self-initiate activities. • Most can attend to and recognize familiar pictures. • Most can follow 1-step instructions and stop an activity upon request. • Most can distinguish between "more" and "less". • Most can separate one object from a group upon request.

Table 6.1. contd

Severity level	Early childhood	Childhood and adolescence	Adulthood
	• Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). **Literacy/numeracy** • Most can make rudimentary marks that are precursors to letters on a page.	• Most can differentiate locations and associate meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Most can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). • With support, some may be able to apply existing abilities in order to build skills for future unskilled employment (i.e. involving performing simple duties) or semi-skilled employment (i.e. involving performing routine operations). **Literacy/numeracy** • Most can recognize symbols. • Many can recognize own name in print.	• Most can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Most can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with) when given concrete choices (e.g. with visual aids). • Some can apply existing skills to obtain unskilled employment (i.e. involving performing simple duties) or semi-skilled employment (i.e. involving performing routine operations) with appropriate social and visual/verbal support. **Literacy/numeracy** • Most can recognize common pictures (e.g. house, ball, flower). • Many can recognize letters from an alphabet.
Profound	• Many will develop nonverbal strategies to communicate basic needs. • Most can attend to and respond to others. • Most can start or stop activities with prompts and aids. • Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids). **Literacy/numeracy** • Children with profound disorders of intellectual development will not learn to read or write.	• Most will develop strategies to communicate basic needs and preferences. • Most can recognize familiar people in person and in photographs. • Most can perform very simple tasks with prompts and aids. • Some can separate one object from a group upon request. • Some can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Many can express their likes and dislikes in relationships (e.g. who they prefer to spend time with), activities, food and dress when given concrete choices (e.g. with visual aids).	• Most will develop nonverbal strategies and some utterances/ occasional words to communicate basic needs and preferences. • Most can attend to and recognize familiar pictures. • Most can perform very simple tasks with prompts and aids. • Some can separate one object from a group upon request. • Some can differentiate locations and associated meanings (e.g. car, kitchen, bathroom, school, doctor's office). • Many can communicate their preferences about their future goals, health care and relationships (e.g. who they prefer to spend time with) when given concrete choices (e.g. with visual aids).

Note: the presence or absence of particular behavioural indicators listed in the table is not sufficient to assign a diagnosis of disorder of intellectual development. Clinical judgement is a necessary component in determining whether an individual has a diagnosable disorder, and diagnosis relies on the following key assumptions being met:

- Limitations in present functioning have been considered within the context of **community environments** typical of the individual's age peers and culture.
- Valid assessment has considered **cultural and linguistic diversity**, as well as differences in communication, sensory, motor and behavioural factors.
- Within an individual, **limitations are recognized to often coexist alongside strengths** and both were considered during the assessment.
- Limitations are described, in part, to develop a **profile of needed support**.
- It is recognized that with **appropriate support over a sustained period**, the life functioning of the affected person generally will improve.
- Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.

Table 6.2. Behavioural indicators of adaptive behaviour, early childhood (up to 6 years of age)

Severity level	Conceptual	Social	Practical
Mild	• Most can perform basic listening skills with a 15-minute attention span. They will need help to sustain their attention for 30 minutes. • Most are able to follow simple 2-step instructions. They will need help following a 3-step or "if-then" type of instruction. • Most can state their age and name and identify close family members when asked. • Many will have a 100-word vocabulary. Most will ask "wh" question (who, what, where, why), but will need help using pronouns and tense verbs. • Most are not able to give a detailed account of their experiences. • Most will understand the simple concepts of time, space, distance and spatial relationships. **Literacy** • Many will not learn reading/ writing skills. If present, reading skills will be limited to identifying some letters of the alphabet. Only some will be able to recognize their own name in print.	• Most can perform independently basic skills related to social interaction – such as imitation and showing affection to familiar people, as well as friend-seeking behaviour – expressing emotions and answering basic questions. • Most will need frequent encouragement and assistance in offering help to others, sharing interests or perspective taking. They are able to engage in play with others, even with minimal supervision, although they will need assistance taking turns, following rules or sharing. • Most are able to demonstrate polite behaviour (saying "please", "thank you"), although they may need help apologizing, demonstrating appropriate behaviour with strangers or waiting for the appropriate moment to speak in a social context. • Most will need help to modify their behaviour in accordance with changing social situations or when there is a change in their routines.	• Most will learn the majority of basic eating, washing face and hands, toileting and self-care skills. • Most will acquire independence in dressing (nut may need help to button/fasten clothes) and night-time continence. • Most can use simple household devices. • Most will need support with bathing, using utensils, toileting such as cleaning after passing stools, and brushing teeth. • Most can learn the concept of danger and avoid hot objects. • Most will be able to help with simple household chores independently, but will often need assistance with more complex tasks such as putting away clothes or cleaning up their rooms. • With some assistance, most can learn the concept of money (although they will be unable to learn the value of the different denominations, e.g. coins), can count to 10, and can follow basic rules around the home. • Most will be unable to learn days of the week, and learn and remember phone numbers.
Moderate	• Most will independently point to common objects when asked and follow 1-step instructions. Some will need support to perform basic skills such as following simple 2-step instructions. • Most can state their own name. • Most will have basic communication skills such as formulating one-word requests, using simple phrases and using other people's customary forms of address (mommy, papa, sister), but will need help with full names. • Most will speak at least 50 words and name/point to at least 10 objects when asked. • Most are not able (or will need considerable support) to use past tense verbs, pronouns or "wh" questions. **Literacy** • Most will not learn reading or writing skills, but will know how to use pens and pencils and make marks on a page.	• Most are able to perform independently some of the basic skills related to social interaction, although they might need some help making new friends, answering basic social questions or expressing their emotions. • Most are able to play with peers and show interest in, play or interact with others, but may need more supervision/support to play cooperatively with others, play symbolically, take turns, follow rules of a game and share objects. • Most will not be able to perform more complex social skills involving interpersonal interactions such as offering help to others, empathy, sharing their interests with others or perspective taking.	• Most can learn the majority of basic eating skills, but may need more assistance than their same-age peers with toilet training and dressing themselves (some help needed to button/fasten). • Most will learn to ask to use the toilet, drink from a cup, feed themselves with a spoon, and some may become toilet trained during daytime. Most will often need support with brushing teeth, bathing and using utensils. • With some support, most can learn to use simple household devices and carry out simple chores such as putting away their footwear. • Most can learn the concept of danger, although some assistance will be needed when using sharp objects (e.g. scissors). • Many will be able to help with very simple household chores such as cleaning fruits and vegetables. • Most will not acquire understanding of the concept of money and time.

Table 6.2. contd

Severity level	Conceptual	Social	Practical
Severe	• Most can perform independently the most basic skills such as wave goodbye, identify parent/caregiver, point to a desired object and point or gesture to indicate their preference, and understanding the meaning of yes and no. • Most will need support to point to/identify common objects, follow 1-step instructions, and sustain their attention to listen to a story for at least 5 minutes. • Most will not be able to state their age correctly and will speak less than 50 recognizable words. They may need help formulating 1-word requests and using first names or nicknames of familiar people, naming objects, answering when called upon, and using simple phrases. **Literacy** • Most will not learn reading and writing skills.	• Most will need help to perform basic social skills such as imitation or showing interest and preferences in social interactions with their peers. • Most are able to show interest when someone else is playful and to play simple games. • Most will need significant support to play in a cooperative way, play symbolically or seek others for play/leisure activities. • Most will need significant help with transitions – changing from one activity to another or an unexpected change in routine. • Most will need significant help using polite social responses such as "please" and "thank you". • Most will not be able to engage in turn-taking, following rules or sharing objects.	• Most can learn many of the basic eating skills but will need substantially more assistance than their same-age peers with toilet training, learning to use a cup and spoon, and putting on clothes. • Most can learn to use simple household devices with consistent support. • Most will have difficulty learning to master many self-care skills, including using the toilet independently. • Most will not be able to learn the concept of danger, and will require close supervision in areas such as the kitchen. • Some may learn basic cleaning skills such as washing hands but will consistently need assistance. • Most will not learn the concept of money, time or numbers.
Profound	• Most will master only the most basic communication skills such as turning their eye gaze and head towards a sound. • Children with profound disorders of intellectual development will typically need prompting to orient towards people in their environment, respond when their name is called, and understand the meaning of yes and no. • Children with profound disorders of intellectual development are typically able to cry when hungry or wet, smile and make sounds of pleasure, but it may be difficult to get their attention. **Literacy** • Children with profound disorders of intellectual development will not learn to read or write.	• Most may be able to perform only the most basic social skills such as smiling, orienting their gaze, looking at others/objects, or showing basic emotions. • Some might be able to perform other basic social skills with considerable support/ prompting, such as showing preference for people or objects, imitating simple movements and expressions, or engaging in reciprocal social interactions. • Some can show interest when someone else is playful, but will need considerable support to play simple games. • Most will have difficulty adapting to changes and transitions in activity/location. • Most will be unable to follow rules of a social game.	• Most will need help performing even the most basic eating, dressing, drinking and bathing skills. • Most will be unable to learn to be independent using the toilet, being dry during the day, bathing or washing self at the sink, and using a fork and knife. • Most will need constant supervision around potentially dangerous situations in the home and community. • Most will be unable to clean up after themselves and will need help with even basic chores, such as picking up belongings to put away. • Most will not be able to learn to use the telephone or other simple devices around the home independently.

Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development, either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual's cultural and linguistic background. Use of these indicators is predicated on the clinician's knowledge of and experience with typically developing individuals of comparable age. Unless explicitly stated, the behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual by 6 years of age. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.

Table 6.3. Behavioural indicators of adaptive behaviour, childhood and adolescence (6–18 years of age)

Severity level	Conceptual	Social	Practical
Mild	• Most will need some help to sustain their attention for a 30-minute period. • Most can follow 3-step instructions. • Most will acquire sufficient communication skills to use pronouns, possessives and regular tenses, as well as be able to ask "wh" question (e.g. who, what, where, when or why). • Many will need support to tell a narrative story or to give someone simple directions. They will also need assistance to explain their ideas using multiple examples, detail short-term goals and steps to achieve them, stay on the topic in group conversations and move from one topic to another. **Literacy** • Most will have reading and writing skills that are limited to approximately those expected of someone who has attended 3–4 years of primary/elementary school.	• Some may have a more concrete understanding of social situations, and may need support understanding some types of humour (e.g. teasing others), making plans and knowing to let others know about these plans as needed, controlling their emotions when faced with disappointment, and knowing to avoid dangerous activities or situations that may not be in their best interest (e.g. taken advantage of or exploited). • Some may need some support initiating conversation, organizing social activities with others or talking about shared interests with peers/friends. • Some may need substantial support to talk about personal things and emotions or understand social cues. • Most are able to play outdoor sports or other social games in groups, although they need help to play games with more complex rules (e.g. board games).	• Most will learn to perform independently most dressing, toileting and eating skills. • Most will learn to manage activities of daily living independently, such as brushing teeth, bathing and showering. • Most will need some support getting around the community and being safe (e.g. although they will know to stay to the side of routes with car traffic, they may continue to need support to check for traffic before crossing a street). • Many may be vulnerable to being taken advantage of in social situations. They may continue to need some support for telling time, identifying correct day/dates on calendar, making and checking the correct change at the store, and being independent with basic health-maintaining behaviours. • If available, many can learn to use computers and cell phones for school and play. • Most will learn basic work skills at nearly the same pace as their same-age peers, but will require greater repetition and structure for mastery.
Moderate	• Most will need help performing skills such as following instructions containing "if-then", and sustaining their attention to listen to a story for at least a 15-minute period. • Most can say at least 100 words, use negatives, use simple sentences and state their first and last name and their locality/place of residence. • Some may need help using pronouns, possessives or past tense verbs. • Some may need support telling basic parts of a story or asking "wh" questions (e.g. when, where, why, who). • Most will not learn complex conversation skills (i.e. expressing their ideas in an abstract manner or in more than one way).	• Some may need support expressing their emotions or concerns, knowing when others might need their help, showing emotions appropriate to the situation/context, or knowing what others like or want. • Most will need considerable help initiating a conversation, waiting for the appropriate moment to speak, meeting friends and going on social outings or talking about shared interests with others. • Most will need help following rules when playing simple games or going out with friends. • Some will need support when changing routines and transitioning between activities/places.	• Most can learn to feed themselves, use the toilet and dress (including putting shoes/footwear on the correct feet). • Most will often continue to need support to attain independence for bathing and showering, brushing teeth, selecting appropriate clothing, and being independent and safe in the home and community. • Most will continue to have difficulty using a knife to cut food, using cooking appliances safely, using household products safely, and doing household chores.

Table 6.3. contd

Severity level	Conceptual	Social	Practical
	Literacy • Most will have reading and writing skills that will be limited to approximately those expected of someone who has attended 2 years of primary/elementary school. • Most may need support with reading simple stories, writing simple sentences, and writing more than 20 words from memory. • Most will be able to say the names of a few animals, fruits and foods prepared in the home.	• Some will need support in behaving appropriately in accordance with social situations, and knowing what to do in social situations involving strangers. • Most individuals will not be able to share information with others about their past day's events/activities, and will need support managing conflicts or challenging social interactions and recognizing/avoiding dangerous social situations.	• Most will not acquire an understanding of taking care of their health. • Most will learn basic work skills but later than same-age peers
Severe	• Most will be able independently to make simple one-word requests, use first names of familiar individuals and name at least 10 familiar objects. • Some may need help following instructions, and will not be able to use pronouns, possessives or regular past tenses, or state their age. • With help, some may be able to ask "wh" questions (e.g. when, why, what, where), use at least 100 recognizable words, use negatives, and relate their experiences in simple sentences. **Literacy** • Most will have reading and writing skills that will be limited to identifying some letters of the alphabet. • Most will be able to count up to 5.	• Some may need support demonstrating friend-seeking behaviour, or engaging in reciprocal social interactions. • Most will need help expressing their emotions or showing empathy. • Most will not know that they should offer help to others without cues or prompting, show appropriate emotions in social situations, engage in conversations or ask others about their interests. • Most will need support to play cooperatively. • Most will need help with transitions – changing from one activity to another, or an unexpected change in routine. • With considerable help, some might be able to start/end a conversation appropriately, and say "please" and "thank you" when appropriate. • Most will have difficulty following social rules, as well as rules associated with games such as turn-taking or sharing toys. Most will be unable to participate in social or other games with complex rules.	• Most can learn to independently put on and take off clothing, feed themselves with hand or a spoon, and use the toilet. • They will often continue to need support to attain independence for putting shoes or other footwear on the correct feet, buttoning and fastening clothing, bathing and showering. • Most individuals will not learn the rules and safe behaviours in the home and community, doing household chores or checking for correct change when purchasing items. • Some will learn basic work skills but later than same-age peers.

Table 6.3. contd

Severity level	Conceptual	Social	Practical
Profound	• Most will have basic communication skills such as orienting their eye gaze and turning their head to locate a sound, responding to their name, getting a parent/caregiver's attention, expressing their needs, and demonstrating an understanding of the meaning of yes and no. • With significant support, some will be able to wave goodbye, use their parent/caregiver's name, and point to objects to express their preferences. • Most indicate when there are hungry or wet by making a vocalization or crying, smile, and make sounds to indicate they are happy/sad. • Some may not be able to effectively use communication to get the attention of others in their environment. **Literacy** • Most will not learn to read or write.	• Most will need some help to perform basic social skills such as showing interest and affection for people familiar to them, engaging in social interactions, or discriminating between acquaintances. • Some can perform certain social skills such as imitation, showing interest in peers or empathy. • For some, transitioning between social contexts and activities will elicit negative reactions if not done with support. • Most will not be able to engage in cooperative social play, and will need a lot of help moderating their behaviour to different social cues.	• Most will need exceptional support with basic hygiene and washing, picking up after themselves, clearing their place at the kitchen table, being safe in the kitchen, and using hot water. • Most will be unable to learn to prepare foods or assist in the kitchen, or use simple household devices (e.g. switches, stoves, microwaves). • Most will not learn rules and safe behaviours in the home and community. • Most will require a lot of supervision to remain on task and be engaged in basic vocational or pre-vocational skills.

Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development, either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual's cultural and linguistic background. Use of these indicators is predicated on the clinician's knowledge of and experience with typically developing individuals of comparable age. Unless explicitly stated, the behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual by 18 years of age. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.

Table 6.4. Behavioural indicators of adaptive behaviour, adulthood (18 years of age and over)

Severity level	Early childhood	Childhood and adolescence	Adulthood
Mild	• Most will master listening and communication skills, although some may need help to stay on topic in group conversations, move from one topic to another, express ideas in more than one way or state their complete home address. • Most will probably not be able to give complex directions and describe long-term goals. **Literacy** • Most can read and understand material up to that expected of someone who has attended 3 or 4 years of primary/elementary school, and will master some writing skills, although they may have difficulty writing reports and long essays.	• Most can meet others independently for the purpose of making new friends, participate in social outings on a regular basis, and talk about personal feelings. • Most can initiate a conversation independently and talk about shared interests with others. • Most can understand social cues, and are able to regulate their conversation based on their interpretation of other people's feelings. • Most are able to play complex social games and team sports, although they may need support with understanding the rules. • Most can learn to weigh the possible consequences of their actions before making a decision in familiar situations but not in new or complex situations, and will know right from wrong. • Most will need help recognizing when a situation or relationship might pose dangers or someone might be manipulating them for their own gain. • Most can initiate planning of a social activity with others. Some can be engaged in an intimate relationship, whereas others might need more support to do so.	• Most will be independent in household chores, be safe around the home, and use the telephone and TV; some will learn to operate a gas or electric stove. • Most will often continue to need some support to attain independence with more complex domestic skills (e.g. small household repairs), comparative shopping for consumer products, following a healthy diet and being engaged in health-promoting behaviours, caring for themselves when sick or knowing what to do when they are sick/ill. • Many can learn to live and work independently, working at a part-time or full-time job with competitive wages – support at work will depend on the level of complexity of the work, and may fluctuate with life transitions. • Some can learn to drive a motor vehicle or a bicycle, manage simple aspects of a bank account, prepare simple meals and, if available, use a computer or other digital devices. Many will learn to use public transport with minimal help. • Most will continue to need support with more complex banking needs, paying bills, driving on busy roads and parenting skills.
Moderate	• Most will need considerable support to be able to attend to various tasks for more than a 15-minute period and to follow instructions or directions from memory (i.e. with a 5-minute delay). • Most will master simple descriptions, using "wh" questions (e.g. what, when, why, where) and relating their experiences using simple sentences. • With help, most are able to follow 3-step instructions. • Most will continue to need help frequently with using language containing past tenses and describing their experiences in detail. • Most will not learn more complex conversation skills (e.g. expressing ideas in more than one way).	• Some will need help learning how to share interests or engaging in perspective taking. • Some may need support initiating conversations and introducing themselves to unfamiliar people. • Most will need significant support engaging in regular social activities, planning social activities with others, understanding social cues, and knowing what are appropriate or inappropriate conversation topics. • Most will need significant support engaging in social activities requiring transportation. • Most are unable to be engaged in more social or other games with complex rules (e.g. board games).	• Some will learn to master dressing (but may need some help selecting appropriate clothing to wear for weather), washing, eating and toileting needs. • Most are able to be safe around the home, use the telephone, use the basic features of a TV and use simple appliances/ household articles (e.g. switches, stoves, microwaves). • Some may continue to need support with bathing and showering, using more complex household appliances (e.g. stoves) safely, meal preparation, or using cleaning products safely. • Many will understand the function of money but will struggle with making change, budgeting and making purchases without being told what to buy.

Table 6.4. contd

Severity level	Early childhood	Childhood and adolescence	Adulthood
	Literacy • Most will acquire some reading and writing skills, such as letters of the alphabet, writing at least three simple words from an example, and writing their own first and last name. They will need significant support to write simple sentences or read simple stories at about the level expected of someone who has attended 2 years of primary/elementary school.	• Most will need help providing socially polite responses such as "please" and "thank you". • Most are unable to recognize when a social situation might pose some danger to them (e.g. potential for abuse or exploitation).	• Most will need support being safe in the community and living independently. They will need substantial support for employment, including finding and keeping a job. • Most will not be able to travel independently to new places, have a developed concept of time sufficient to tell time independently and know when they are late.
Severe	• Most will often need lifelong support to recall and comply with instructions given 5 minutes prior, and sustain their attention to a story for a 15-minute period. Most are able to listen and attend to a story for a period of at least 5 minutes. • Most can make sounds or gestures to get the attention of individuals in their environment, and can make their needs known. • They may need help using simple phrases, describing objects and relating their experiences to others, speaking at least 100 recognizable words, and using negatives, possessives and pronouns, and asking "wh" questions. **Literacy** • Reading and writing skills will be limited to identifying some letters of the alphabet, copying simple words from an example and attempting to write their name.	• All will need help in social situations, showing and expressing their emotions in an appropriate manner, and engaging in a reciprocal conversation with others. • Most can play simple social games such as catching and throwing a ball, but may need help choosing friends to play with. They will need considerable help to play symbolically and follow the rules while playing games, such as turn-taking or sharing toys. • Most will need help with transition – changing from one activity to the next or an unexpected change in routine. • Most will not spontaneously use polite forms such as "please", "excuse me", "thank you" and so on, or respectful/customary ways of addressing others. They will need significant support starting, maintaining and ending conversations with others. • Most will not recognize when a social situation might pose a danger to them (e.g. potential for abuse or exploitation) or discern dangers potentially associated with strangers.	• Most will need some support for even basic personal hygiene, domestic skills, home and community skills. • Most will be able to drink independently from a cup and learn to use basic utensils for eating. Some may continue to need support getting dressed. • Many may learn independent toileting if provided an established routine. Most will be unable to care for their own belongings, perform household chores independently, cooking or care for their health. • Most will need substantial support to travel independently, plan and do shopping and banking of any sort. • Most will require significant support to be engaged in paid employment.
Profound	• Most are able to turn their head and eye gaze towards sounds in their environment and respond to their name when called. • Most will use sounds and gestures to get a parent/caregiver's attention or express their wants, and some will have an understanding of the meaning of yes and no. Some are able with prompting to wave goodbye, use their parent's/caregiver's name / customary ways of addressing others, and point to objects to express their preferences.	• Most will not spontaneously show interest in peers or unfamiliar individuals. • With significant support, most are able to imitate simple actions/behaviours or show concern for others. • Most will not engage in reciprocal/ back-and-forth conversation. • Most will not spontaneously use polite forms such as "please", "excuse me", "thank you" and so on.	• Most will need support performing even the most basic self-care, eating, washing and domestic skills. • Some may learn independent toileting during the day, but night-time continence will be more difficult. • Most will have difficulty picking out appropriate clothing, and zipping and snapping clothes. • Most will need supervision and support for bathing, including safely adjusting water temperature and washing/drying.

Table 6.4. contd

Severity level	Early childhood	Childhood and adolescence	Adulthood
Profound	• Most will cry or make vocalizations when hungry or wet, smile, and make sounds of pleasure. • Most are not able to follow instructions or story being told. • Most will have only rudimentary knowledge of moving around within their house. **Literacy** • Most will not learn to read or write.	• Most are unable to anticipate changes in routines. Social interactions with others will be very basic and limited to essential wants and needs. • Most are unable to recognize when a social situation might pose some danger to them (e.g. potential for abuse or exploitation).	• Most will be unable to clean or care for their living environment independently, including clothing and meal preparation. • All will need substantial support with health matters, being safe in the home and community, and learning the concept of days of the week and time of day. • Most will be extremely limited in their vocational skills, and engagement in employment activities will necessitate structure and support.

Note: the behavioural indicators in the table are intended to be used by the clinician in determining the level of severity of the disorder of intellectual development either as a complement to properly normed, standardized tests, or when such tests are unavailable or inappropriate given the individual's cultural and linguistic background. Use of these indicators is predicated on the clinician's knowledge of and experience with typically developing individuals of comparable age. The behavioural indicators of intellectual functioning and adaptive behaviour functioning for each severity level are what are typically expected to be mastered by the individual as an adult. Please consult the CDDR for disorders of intellectual development and, if applicable, autism spectrum disorder for guidance on how to determine the severity level.

6A01 Developmental speech and language disorders

Developmental speech and language disorders are characterized by difficulties in understanding or producing speech and language or in using language in context for the purposes of communication. Developmental speech of language disorders include:

6A01.0 Developmental speech sound disorder

6A01.1 Developmental speech fluency disorder

6A01.2 Developmental language disorder

6A01.Y Other specified developmental speech or language disorder

6A01.Z Developmental speech or language disorder, unspecified.

Regional, social or cultural/ethnic language variations (e.g. dialects) must be considered when an individual is being assessed for language abilities. For example, phonological memory tasks may offer a less biased assessment compared to lexical tasks. A language history documenting all the languages the child has been exposed to since birth can assist in determining whether individual language variations are better explained by exposure to multiple languages rather than a speech or language pathology per se.

6A01.0 Developmental speech sound disorder

Essential (required) features

- Persistent errors of pronunciation, articulation or phonology (i.e. how language-based sounds are combined in culture-typical speech) that manifest as developmentally typical speech sound errors that persist substantially beyond the expected age or as atypical speech sound errors for the language spoken (e.g. word initial consonant deletion for English-speaking children) are required for diagnosis.
- The onset of speech sound difficulties occurs during the early developmental period.
- Speech sound difficulties result in significant limitations in the ability to communicate due to reduced intelligibility of speech.
- The speech errors are not better accounted for by a disease of the nervous system affecting the brain, peripheral nerves or neuromusculature (e.g. cerebral palsy, myasthenia gravis); a sensory impairment (e.g. sensory neural deafness); or a structural abnormality (e.g. cleft palate) or other medical condition.

Additional clinical features

- Children with developmental speech sound disorder may exhibit delays in the acquisition, production and perception of spoken language.

- Phonological speech sound errors may be consistent or inconsistent. They often involve classes of sounds (e.g. incorrectly producing sounds in the same manner), a different place of articulation, or changes in syllable structure (e.g. deletion of final consonants or reducing consonant clusters to single consonants).
- If the speech errors are consistently produced, familiar listeners may be able to accommodate and decode the speech. However, when the rate of speech increases, even familiar listeners may not be able to understand the individual.
- Developmental speech sound disorder may be associated with imprecision and inconsistency of oral movements required for speech, especially in young children (also called childhood apraxia or dyspraxia of speech), resulting in difficulty producing sequences of speech sounds, specific consonants and vowels, and appropriate prosody (intonation and rhythm of speech). There may be some associated oral-motor dysfunction affecting early feeding, sucking and chewing, blowing, and imitating oral movements and speech sounds, but not with the weakness, slowness or incoordination found in dysarthria.
- Developmental speech sound disorder commonly co-occurs with other neurodevelopmental disorders, such as attention deficit hyperactivity disorder, developmental speech fluency disorder and developmental language disorder.

Boundary with normality (threshold)

- Children vary widely in the sequence and age at which they acquire speech sounds. Such normal variation does not reflect the presence of developmental speech sound disorder. In contrast, children with developmental speech sound disorder exhibit persistent problems that cause significant limitations in the ability to communicate due to reduced intelligibility of speech. Up until the age of 4 years, various speech sound errors are common among children with typically developing speech sound acquisition, but communication remains relatively intact despite these errors, relative to same-aged peers.

Course features

- Many young children with developmental speech sound disorder experience remission by school age. Among young children diagnosed in early childhood, up to 50–70% will exhibit academic difficulties throughout their schooling, even if the speech sound difficulties themselves have remitted.
- Compared to children and adolescents with a sole diagnosis of developmental speech sound disorder, those with a co-occurring developmental language disorder are more likely to develop other mental, behavioural and neurodevelopmental disorders such as anxiety and fear-related disorders or attention deficit hyperactivity disorder. They are also more likely to exhibit greater difficulties academically, socially and adaptively by late childhood and adolescence.

Developmental presentations

- Prevalence rates vary but generally decrease with age such that prevalence can be as high as 16% at 3 or 4 years of age, approximately 4% at 6 years of age and 3.6% by 8 years of age. Therefore, many preschool-aged children diagnosed with developmental speech sound disorder exhibit typical speech sound development by the time they begin school.
- Some children with symptoms of developmental speech sound disorder early in life may only experience interference with functioning when they enter school, when the demands of the learning environment exceed their current abilities.
- Co-occurrence of other neurodevelopment disorders is more likely among children with persistent developmental speech sound disorder (whose speech sound errors continue beyond 8 or 9 years of age). In particular, these children are more likely to develop language impairments and reading difficulties, and tend to experience worse outcomes.

Sex- and/or gender-related features

- Developmental speech sound disorder is more prevalent among boys, especially at younger ages. Early speech difficulties in girls appear more likely to resolve by school age. Gender differences decline with age: the ratio of boys to girls affected appears to be 2:1 or 3:1 in early childhood, and to decline to 1.2:1 by 6 years of age.
- Boys are more likely to experience co-occurring language impairments.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Individuals with a disorder of intellectual development may exhibit impaired speech production. However, individuals with developmental speech sound disorder do not typically also have significant limitations in intellectual functioning and adaptive behaviour. If speech production difficulties require separate clinical attention in the context of a disorder of intellectual development, an additional diagnosis of developmental speech sound disorder may be assigned.

Boundary with developmental speech fluency disorder and developmental language disorder

Like developmental speech sound disorder, developmental speech fluency disorder and developmental language disorder can result in reduced intelligibility that significantly affects communication. Developmental speech fluency disorder is characterized by disruption of the normal rhythmic flow and rate of speech. Developmental language disorder is characterized by persistent difficulties in the acquisition, understanding, production or use of language. In contrast, developmental speech sound disorder is characterized by errors of pronunciation that are outside the limits of normal variation for chronological or developmental age.

Boundary with selective mutism

Selective mutism is characterized by consistent selectivity in speaking, such that a child demonstrates adequate speech production in specific situations (typically at home) but predictably fails to speak in others (typically at school). Selective mutism can occur in the presence of developmental speech sound disorder, and both diagnoses may be assigned if warranted.

Boundary with dysphonia

Dysphonia is characterized by abnormal voice production or absences of vocal quality, pitch, loudness, resonance or duration. It can be caused by voice strain or overuse, by structural laryngeal anomalies, or by diseases of the nervous system. It may result in the distortion of speech sounds due to the abnormal voice quality. In contrast, developmental speech sound disorder involves the omission or substitution of speech sounds and also includes distortion of speech sounds (e.g. due to incorrect tongue placement) rather than abnormal voice quality characteristic of dysphonia.

Boundary with dysarthria

Dysarthria is a motor speech disorder directly attributable to a disease of the nervous system or to either congenital or acquired brain injury. Dysarthria is characterized by difficulties with the range, rate, force, coordination and sustainability of movements throughout the vocal tract (i.e. trunk, larynx, palate, tongue, lips, jaw and face) that are required for speech. These motor difficulties often also cause frank difficulties in eating, drinking, swallowing or saliva control. A diagnosis of developmental speech sound disorder should not be assigned in these cases. Rather, a diagnosis of secondary speech or language syndrome should be assigned in addition to the associated medical condition if the speech sound difficulties are a specific focus of clinical attention.

Boundary with secondary speech or language syndrome

The diagnosis of developmental speech sound disorder should not be assigned in the presence of a disease of the nervous system affecting the brain, peripheral nerves or neuromusculature (e.g. cerebral palsy, myasthenia gravis); sensory impairment (e.g. sensory neural deafness); or structural impairment (e.g. cleft palate), although speech sound production difficulties may be a presenting feature of any of these conditions. In these cases, a diagnosis of secondary speech or language syndrome should be assigned in addition to the associated medical condition if the speech sound difficulties are a specific focus of clinical attention.

6A01.1 Developmental speech fluency disorder

Essential (required) features

- Frequent or pervasive disruption of the normal rhythmic flow and rate of speech characterized by repetitions and prolongations in sounds, syllables, words and phrases, as well as blocking (inaudible or silent fixations or inability to initiate sounds) and word avoidance or substitutions, is required for diagnosis.
- The speech dysfluency is persistent over time.
- The onset of speech dysfluency occurs during the developmental period, and speech fluency is markedly below what would be expected based on age.
- Speech dysfluency results in significant impairment in social communication or in personal, family, social, educational, occupational or other important areas of functioning.
- The speech dysfluency is not better accounted for by a disorder of intellectual development, a disease of the nervous system, a sensory impairment or a structural abnormality.

Additional clinical features

- Developmental speech fluency disorder includes cluttering, in which speech tends to be rapid, erratic and dysrhythmic, with breakdown in fluency and clarity, often with deletion or collapsing of syllables and omissions of word endings.
- Developmental speech fluency disorder may be accompanied by physical tension in the speech musculature, as well as body tension, struggle behaviour and secondary mannerisms, such as facial grimacing, eye blinking, head movements, and arm and leg movements such as leg tapping or fist clenching.
- Developmental speech fluency disorder is often accompanied by anxiety in anticipation of speaking and avoidance of speaking.
- The extent of the problem varies across situations and can be more severe when there is pressure to communicate.
- Developmental speech fluency disorder may be associated with a broader range of speech and language abnormalities.
- Occasionally, onset of dysfluency can be related to a significant psychological event such as bereavement, and is sometimes referred to as "psychogenic stammering". When this occurs during the developmental period, it may be diagnosed as developmental speech fluency disorder.
- Approximately 60% of children with developmental speech fluency disorder exhibit co-occurring developmental speech and language disorders.
- Among adolescents and adults with chronic speech dysfluencies, social anxiety is common and may exacerbate dysfluency. As many as 40–60% of these individuals meet the diagnostic requirements for social anxiety disorder.

Boundary with normality (threshold)

- Many typically developing children show minor dysfluencies during the preschool years.

Course features

- The course of developmental speech fluency disorder may be relatively brief in many cases, with the majority of children (65–85%) remitting, without intervention, prior to puberty. Among these children, recovery is typically within the first 2 years after onset.
- The impact of developmental speech fluency disorder may be evident as early as 3 years of age, with impairments in emotional, behavioural and social domains compared to typically developing peers.

- A more persistent course is associated with male gender, family history of developmental speech fluency disorder, age at onset of greater than 3–4 years of age, duration of more than 1 year, and co-occurring developmental language disorder. More severe presentations of the disorder in childhood are more likely to persist into adolescence and adulthood.

Developmental presentations

- Developmental speech fluency disorder emerges early in the developmental period, typically between 2.5 and 4 years of age. Around 5–8% of preschool-aged children exhibit stuttering; 80–90% of cases develop by age 6, and onset after age 9 is rare. The lifetime incidence of stuttering is estimated at 5%, whereas population prevalence is estimated at approximately 1%.
- Dysfluency tends to emerge gradually and may worsen as the individual becomes aware of their fluency difficulty. This may lead to development of mechanisms to avoid dysfluency or the associated emotional discomfort, further impairing speech (e.g. avoiding public speaking or limiting speech to simple and short phrases).

Sex- and/or gender-related features

- Across the developmental period, boys are more commonly affected. Among preschool-aged children, the ratio of boys to girls with developmental speech fluency disorder is estimated at 1.5:1. However, females are more likely to remit. Throughout school age and into adulthood, affected males are estimated to outnumber affected females by a ratio of 4:1.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with developmental speech sound disorder and developmental language disorder

Like developmental speech fluency disorder, developmental speech sound disorder and developmental language disorder can result in reduced intelligibility that significantly affects communication. Developmental speech sound disorder is characterized by errors of pronunciation that are outside the limits of normal variation for chronological or developmental age. Developmental language disorder is characterized by persistent difficulties in the acquisition, understanding, production or use of language. In contrast, developmental speech fluency disorder is characterized by disruption of the normal rhythmic flow and rate of speech. If the diagnostic requirements for both developmental fluency disorder and another developmental speech and language disorder are met, both diagnoses may be assigned.

Boundary with primary tics and tic disorders, including Tourette syndrome

Dysfluency associated with other movements of the face or body that coincide in time with repetitions, prolongations or pauses in speech flow needs to be differentiated from complex tics. Tics do not involve the marked speech dysfluency that characterizes a developmental speech fluency disorder.

Boundary with diseases of the nervous system

Diseases of the nervous system affecting the anatomical and functional mechanisms for speech output can sometimes give rise to speech dysfluency, but are distinguished on examination by the presence of positive neurological signs.

6A01.2 Developmental language disorder

Essential (required) features

- Persistent deficits in the acquisition, understanding, production or use of language (spoken or signed) are required for diagnosis. Any of the following specific components of language skill may be differentially impaired, with relative weaknesses in some and relative strengths in others, or impairment may be more consistent across the different component skills:
  - the ability to decompose words into constituent sounds and mentally manipulate those sounds (i.e. phonological awareness);
  - the ability to use language rules – for example, regarding word endings and how words are combined to form sentences (i.e. syntax, morphology or grammar);
  - the ability to learn, understand and use language to convey the meaning of words and sentences (i.e. semantics);
  - the ability to tell a story or have a conversation (i.e. narrative or conversational discourse);
  - the ability to understand and use language in social contexts – for example, making inferences, understanding verbal humour and resolving ambiguous meaning (i.e. pragmatics).
- Language abilities are markedly below what would be expected based on age.
- The onset of language difficulties occurs during the developmental period – typically during early childhood.
- Language deficits result in significant limitations in communication, with functional impact in daily life at home, school or work.
- The language deficits are not better accounted for by a disorder of intellectual development, autism spectrum disorder, another neurodevelopmental disorder, a sensory impairment, or a disease of the nervous system, including the effects of brain injury or infection (e.g. due to trauma, stroke, epilepsy or meningitis).

Specifiers for areas of language impairment

The *main areas* of language ability currently affected in developmental language disorders should be characterized using one of the following specifiers, although these may vary over time:

6A01.20 Developmental language disorder with impairment of receptive and expressive language

- This specifier should be applied when the ability to learn and understand spoken or signed language (i.e. receptive language) is markedly below the expected level for the individual's age, and is accompanied by persistent impairment in the ability to produce and use spoken or signed language (i.e. expressive language).

6A01.21 Developmental language disorder with impairment of mainly expressive language

- This specifier should be applied when the ability to produce and use spoken or signed language (i.e. expressive language) is markedly below the expected level for the individual's age, but the ability to understand spoken or signed language (i.e. receptive language) is relatively intact.

6A01.22 Developmental language disorder with impairment of mainly pragmatic language

- This specifier should be applied when the developmental language disorder is characterized by persistent and substantial difficulties with the understanding and use of language in social contexts – for example, making inferences, understanding verbal humour and resolving ambiguous meaning. Receptive and expressive language skills are relatively unimpaired, but pragmatic language abilities are markedly below the expected level for the individual's age, and interfere with functional communication to a greater degree than with other components of language (e.g. syntax, semantics). This specifier should not be used if the pragmatic language impairment occurs in the context of a diagnosis of autism spectrum disorder.

6A01.23 Developmental language disorder with other specified language impairment

- This specifier should be applied if the developmental language disorder meets all the diagnostic requirements of the disorder but the pattern of deficits in language is not adequately characterized by one of the other available specifiers.

Additional clinical features

- In typical development, understanding and production of the different components of language are tightly correlated and develop in tandem. In developmental language disorder, this developmental relationship may be out of step, with differential impairment in any of the component language skills.
- Many children with developmental language disorder exhibit a discrepancy between verbal and nonverbal ability, but this is not a requirement for diagnosis.
- Developmental language disorder frequently co-occurs with other neurodevelopmental disorders, such as developmental speech sound disorder, developmental learning disorder, attention deficit hyperactivity disorder, autism spectrum disorder and developmental motor coordination disorder.
- Developmental language disorder is often associated with difficulties in peer relationships, emotional disturbance and disruptive behaviours, particularly in school-aged children.
- Developmental language disorder often runs in families.
- Developmental language disorder can be a presenting feature in some individuals with specific chromosomal anomalies, including sex chromosome anomalies. Where available, chromosome testing can assist in identifying other health risks associated with specific underlying chromosomal abnormalities. If a specific chromosomal or other developmental anomaly is identified, this should be diagnosed in addition to the developmental language disorder.
- Regression of language skills once acquired is not a feature of developmental language disorder. Reported loss of early first words in the second year of life associated with a decline in social and communication behaviours – and, more rarely, loss of language skills after 3 years of age – may be a presentation of autism spectrum disorder. Language abilities may also be lost due to diseases of the nervous system including acquired brain injury from stroke, trauma or encephalopathy with or without overt epilepsy. Concomitant loss of physical skills with language abilities may be indicative of a neurodegenerative condition. When an underlying neurological cause has been identified, the condition should not be diagnosed as developmental language disorder but rather as secondary speech or language syndrome, which should be assigned in addition to the appropriate diagnosis for the underlying condition.

Boundary with normality (threshold)

- Children vary widely in the age at which they first acquire spoken language and in the pace at which language skills become firmly established. The majority of preschool-aged children who acquire speech later than expected go on to develop normal language abilities. Very early delays in language acquisition are therefore not indicative of developmental language disorder. However, the absence of single words (or word approximations) by 2 years of age, the failure to generate simple two-word phrases by 3 years of age, and language impairments that are persistent over time are more likely to indicate developmental language disorder, especially in the context of a known family history of language or literacy learning problems. By 4 years of age, individual differences in language ability are more stable.

- Pronunciation and language use may vary widely depending on the social, cultural and other environmental context (e.g. regional dialects). However, within any typical cultural setting, a developmental language disorder is characterized by significant deficits in language abilities relative to the person's same-aged peers in the community. A bilingual environment is not a cause of persistent language learning impairment.

Course features

- The course of developmental language disorder may vary with the type and severity of symptom profile: impairment of receptive and expressive language (compared to those with impairment of mainly expressive language) is more likely to be persistent, and is associated with subsequent difficulties in reading comprehension.
- The particular pattern of language strengths and deficits may change over the course of development.
- Unlike developmental speech sound and speech fluency disorders, developmental language disorder is more likely to be maintained throughout development and into adulthood: approximately 75% of individuals diagnosed with developmental language disorder in childhood continue to meet the diagnostic requirements for the disorder in late adolescence. The impact of these impairments continues to be evident into early adulthood as behavioural, social, adaptive and communication problems, often with lifelong social consequences.

Developmental presentations

- Developmental language disorder emerges early in development, though it can be challenging to distinguish typical variations from impairments in language development prior to age four. Diagnosis from 4 years of age onwards tends to yield a more stable symptom presentation, and is more likely to be persistent.
- The prevalence of developmental language disorder among children is estimated at 6–15%, but is more common among children with other co-occurring neurodevelopmental disorders.

Sex- and/or gender-related features

- Developmental language disorder appears to affect more boys than girls, though this gender ratio varies across clinical and population-based samples (from 1.3:1 to 6:1).
- Boys appear to be more likely than girls to experience co-occurring developmental language and developmental speech sound disorders.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Individuals with disorders of intellectual development may exhibit delays in language onset, or development or impairment in language abilities, accompanied by generalized impairment in intellectual and adaptive behaviour functioning. Developmental language disorder can occur with varying levels of intellectual ability. If the diagnostic requirements of a disorder of intellectual development are met and language abilities are significantly below what would be expected based on the general level of intellectual functioning and adaptive behaviour, both diagnoses may be assigned.

Boundary with developmental speech sound disorder and developmental speech fluency disorder

Like developmental language disorder with impairment in mainly expressive language, developmental speech sound disorder and developmental speech fluency disorder can result in reduced intelligibility that significantly affects communication. Developmental speech sound disorder is characterized by errors of pronunciation that are outside the limits of normal variation for chronological developmental age. Developmental speech fluency disorder is characterized by disruption of the normal rhythmic flow and rate of speech. In contrast, developmental language disorder is characterized by persistent difficulties in the acquisition, understanding, production or use of language.

Boundary with autism spectrum disorder

Individuals with autism spectrum disorder often present with delayed language development. The extent of functional language impairment, which refers to the capacity of the individual to use language for instrumental purposes (e.g. to express personal needs and desires), should be coded using the autism spectrum disorder *functional language impairment* specifier rather than using a separate diagnosis of developmental language disorder. Moreover, pragmatic language impairment is a characteristic feature of autism spectrum disorder even when other aspects of receptive and expressive speech are intact. Autism spectrum disorder is differentiated from developmental language disorder by the presence of additional impairments in social reciprocity as well as restricted, repetitive and stereotyped behaviours. Unlike individuals with autism spectrum disorder, individuals with developmental language disorder are usually able to initiate and respond appropriately to social and emotional cues and to share interests with others, and do not typically exhibit restricted, repetitive and stereotyped behaviours. An additional diagnosis of developmental language disorder should not be assigned to individuals with autism spectrum disorder based solely on pragmatic language impairment. However, both diagnoses may be assigned if there are additional specific impairments in semantic, syntactic and phonological development.

Boundary with developmental learning disorder

Persistent deficits in the acquisition, understanding, production or use of language in developmental language disorder may lead to academic learning difficulties, especially in literacy – including word reading, comprehension and written output. If all diagnostic requirements for both developmental language disorder and developmental learning disorder are met, both diagnoses may be assigned.

Boundary with selective mutism

Selective mutism is characterized by consistent selectivity in speaking, such that a child demonstrates adequate language competence in specific social situations (typically at home) but predictably fails to speak in others (typically at school). In contrast, language difficulties associated with developmental language disorder are apparent in all settings. However, selective mutism and developmental language disorder can co-occur, and both diagnoses may be assigned if warranted.

Boundary with diseases of the nervous system and sequelae of brain injury or infection

Language impairment may result from brain damage due to stroke, trauma, infection (e.g. meningitis/encephalitis), developmental encephalopathy with or without overt epilepsy, or syndromes of regression (e.g. Landau-Kleffner syndrome or acquired epileptic aphasia). When language difficulties are a specific focus of clinical attention, a diagnosis of secondary speech or language syndrome should be assigned in addition to the associated medical condition.

Boundary with oral language delay or impairment due to hearing impairment

All children presenting with language impairment should have an assessment for hearing impairment because language delay may be better accounted for by hearing impairment. Very young children with hearing impairment usually compensate for lack of oral language by using nonverbal modes of communication (e.g. gestures, facial expressions, eye gaze). However, presence of hearing loss does not preclude a diagnosis of developmental language disorder if the language problems are disproportionate relative to the severity of hearing loss. Developmental language disorder can be assigned to children whose primary communication modality is through signing if exposure to and opportunity to learn sign language has been adequate and the other features of the disorder are present as they apply to sign language.

Boundary with other medical conditions involving loss of acquired language skills

When loss of acquired language skills occurs as a result of another medical condition (e.g. a stroke), and language difficulties are a specific focus of clinical attention, a diagnosis of secondary speech or language syndrome should be assigned in addition to the associated medical condition rather than a diagnosis of developmental language disorder.

6A01.Y Other specified developmental speech or language disorder

Essential (required) features

- Persistent difficulties in understanding or producing speech or language or in using language in context for the purposes of communication that are not better accounted for by developmental speech sound disorder, developmental speech fluency disorder, developmental language disorder or autism spectrum disorder are required for diagnosis.
- The speech or language difficulties are persistent over time.
- The onset of the speech or language difficulties occurs during the developmental period, and speech or language abilities in the affected areas are markedly below what would be expected based on age.
- The speech or language difficulties result in significant impairment in social communication, or in personal, family, social, educational, occupational or other important areas of functioning.
- The speech or language difficulties are not better accounted for by a disorder of intellectual development, a disease of the nervous system, a sensory impairment or a structural abnormality.

6A01.Z Developmental speech or language disorder, unspecified

6A02 Autism spectrum disorder

Essential (required) features

- Persistent deficits in initiating and sustaining social communication and reciprocal social interactions that are outside the expected range of typical functioning based on the individual's age and level of intellectual development are required for diagnosis. Specific manifestations of these deficits vary according to chronological age, verbal and intellectual ability, and disorder severity. Manifestations may include limitations in the following:
  - understanding of, interest in, or inappropriate responses to the verbal or nonverbal social communications of others;
  - integration of spoken language with typical complimentary nonverbal cues, such as eye contact, gestures, facial expressions and body language (these nonverbal behaviours may also be reduced in frequency or intensity);
  - understanding and use of language in social contexts and ability to initiate and sustain reciprocal social conversations;
  - social awareness, leading to behaviour that is not appropriately modulated according to the social context;
  - ability to imagine and respond to the feelings, emotional states and attitudes of others;
  - mutual sharing of interests;
  - ability to make and sustain typical peer relationships.
- Persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and sociocultural context are an essential component. These may include:
  - lack of adaptability to new experiences and circumstances, with associated distress, that can be evoked by trivial changes to a familiar environment or in response to unanticipated events;
  - inflexible adherence to particular routines – for example, these may be geographical, such as following familiar routes, or may require precise timing such as mealtimes or transport;
  - excessive adherence to rules (e.g. when playing games);
  - excessive and persistent ritualized patterns of behaviour (e.g. preoccupation with lining up or sorting objects in a particular way) that serve no apparent external purpose;
  - repetitive and stereotyped motor movements such as whole-body movements (e.g. rocking), atypical gait (e.g. walking on tiptoes), unusual hand or finger movements and posturing (these behaviours are particularly common during early childhood);
  - persistent preoccupation with one or more special interests, parts of objects or specific types of stimuli (including media), or an unusually strong attachment to particular objects (excluding typical comforters);
  - lifelong excessive and persistent hypersensitivity or hyposensitivity to sensory stimuli or unusual interest in a sensory stimulus, which may include actual or anticipated sounds, light, textures (especially clothing and food), odours and tastes, heat, cold or pain.
- The onset of the disorder occurs during the developmental period – typically in early childhood – but characteristic symptoms may not become fully manifest until later, when social demands exceed limited capacities.

- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Some individuals with autism spectrum disorder are able to function adequately in many contexts through exceptional effort, such that their deficits may not be apparent to others. A diagnosis of autism spectrum disorder is still appropriate in such cases.

Specifiers for characterizing features within the autism spectrum

These specifiers enable the identification of co-occurring limitations in intellectual and functional language abilities, which are important factors in the appropriate individualization of support, selection of interventions and treatment planning for individuals with autism spectrum disorder. A specifier is also provided for loss of previously acquired skills, which is a feature of the developmental history of a small proportion of individuals with autism spectrum disorder.

Co-occurring disorder of intellectual development

Individuals with autism spectrum disorder may exhibit limitations in intellectual abilities. If present, a separate diagnosis of disorder of intellectual development should be assigned, using the appropriate category to designate severity (i.e. mild, moderate, severe, profound, provisional). Because social deficits are a core feature of autism spectrum disorder, the assessment of adaptive behaviour as a part of the diagnosis of a co-occurring disorder of intellectual development should place greater emphasis

on the intellectual, conceptual and practical domains of adaptive functioning than on social skills. If no co-occurring diagnosis of disorder of intellectual development is present, the following specifier for the autism spectrum disorder diagnosis should be applied:

- without disorder of intellectual development.

If there is a co-occurring diagnosis of disorder of intellectual development, the following specifier for the autism spectrum disorder diagnosis should be applied, in addition to the appropriate diagnostic code for the co-occurring disorder of intellectual development:

- with disorder of intellectual development.

Degree of functional language impairment

The degree of impairment in functional language (spoken or signed) should be designated with a second specifier. Functional language refers to the capacity of the individual to use language for instrumental purposes (e.g. to express personal needs and desires). This specifier is intended to reflect primarily the verbal and nonverbal expressive language deficits present in some individuals with autism spectrum disorder, and not the pragmatic language deficits that are a core feature of autism spectrum disorder.

The following specifiers should be applied to indicate the extent of functional language impairment (spoken or signed) relative to the individual's age:

- **with mild or no impairment of functional language**
- **with impaired functional language** (i.e. not able to use more than single words or simple phrases)
- **with complete, or almost complete, absence of functional language.**

Table 6.5 shows the diagnostic codes corresponding to the categories that result from the application of the specifiers for co-occurring disorder of intellectual development and degree of functional language impairment.

Table 6.5. Diagnostic codes for autism spectrum disorder

	With mild or no impairment of functional language	With impaired functional language	With complete, or almost complete, absence of functional language
Without disorder of intellectual development	6A02.0	6A02.2	____
With disorder of intellectual development	6A02.1	6A02.3	6A02.5

6A02.Y Other specified autism spectrum disorder can be used if the above parameters do not apply.

6A02.Z Autism spectrum disorder, unspecified, can be used if the above parameters are unknown.

Loss of previously acquired skills

A small proportion of individuals with autism spectrum disorder may present with a loss of previously acquired skills. This regression typically occurs during the second year of life and most often involves language use and social responsiveness. Loss of previously acquired skills is rarely observed after 3 years of age. If it occurs after age 3, it is more likely to involve loss of cognitive and adaptive skills (e.g. loss of bowel and bladder control, impaired sleep), regression of language and social abilities, and increasing emotional and behavioural disturbances.

There are two alternative specifiers to denote whether or not loss of previously acquired skills is an aspect of the clinical history, where *x* corresponds to the final digit shown in Table 6.5:

- **6A02.*x*0 without loss of previously acquired skills**
- **6A02.*x*1 with loss of previously acquired skills.**

Additional clinical features

- Common symptom presentations of autism spectrum disorder in young children are parental or caregiver concerns about intellectual or other developmental delays (e.g. problems in language and motor coordination). When there is no significant impairment of intellectual functioning, clinical services may only be sought later (e.g. due to behaviour or social problems when starting school). In middle childhood, there may be prominent symptoms of anxiety, including social anxiety disorder, school refusal and specific phobia. During adolescence and adulthood, depressive disorders are often a presenting feature.
- Co-occurrence of autism spectrum disorder with other mental, behavioural and neurodevelopmental disorders is common across the lifespan. In a substantial proportion of cases – particularly in adolescence and adulthood – it is a co-occurring disorder that first brings an individual with autism spectrum disorder to clinical attention.
- Pragmatic language difficulties may manifest as an overly literal understanding of others' speech, speech that lacks normal prosody and emotional tone and therefore appears monotonous, lack of awareness of the appropriateness of their choice of language in particular social contexts, or pedantic precision in the use of language.
- Social naivety, especially during adolescence, can lead to exploitation by others – a risk that may be enhanced by the use of social media without adequate supervision.
- Profiles of specific cognitive skills in autism spectrum disorder as measured by standardized assessments may show striking and unusual patterns of strengths and weaknesses that are highly variable from individual to individual. These deficits can affect learning and adaptive functioning to a greater extent than would be predicted from the overall scores on measures of verbal and nonverbal intelligence.
- Self-injurious behaviours (e.g. hitting one's face, head banging) occur more often in individuals with co-occurring disorder of intellectual development.
- Some young individuals with autism spectrum disorder – especially those with a co-occurring disorder of intellectual development – develop epilepsy or seizures during early childhood with a second increase in prevalence during adolescence. Catatonic states have also been described. A number of medical disorders such as tuberous sclerosis, chromosomal abnormalities including fragile X syndrome, cerebral palsy, early-onset epileptic encephalopathies and neurofibromatosis are associated with autism spectrum disorder with or without a co-occurring disorder of intellectual development. Genomic deletions, duplications and other genetic abnormalities are increasingly described in individuals with autism spectrum disorder, some of which may be important for genetic counselling. Prenatal exposure to valproate is also associated with an increased risk of autism spectrum disorder.
- Some individuals with autism spectrum disorder are capable of functioning adequately by making an exceptional effort to compensate for their symptoms during childhood, adolescence or adulthood. Such sustained effort, which may be more typical of affected females, can have a deleterious impact on mental health and well-being.

Boundary with normality (threshold)

Social interaction skills

Typically developing individuals vary in the pace and extent to which they acquire and master skills of reciprocal social interaction and social communication. A diagnosis of autism spectrum disorder should only be considered if there is marked and persistent deviation from the expected range of abilities and behaviours in these domains given the individual's age, level of intellectual functioning and sociocultural context. Some individuals may exhibit limited social interaction due to shyness (i.e. feelings of awkwardness or fear in new situations or with unfamiliar people) or behavioural inhibition (i.e. being slow to approach or to "warm up" to new people and situations). Limited social interactions in shy or behaviourally inhibited children, adolescents or adults are not indicative of autism spectrum disorder. Shyness is differentiated from autism spectrum disorder by evidence of adequate social communication behaviours in familiar situations.

Social communication skills

Children vary widely in the age at which they first acquire spoken language and the pace at which their speech and language become firmly established. Most children with early language delay eventually acquire similar language skills to those of their same-age peers. Early language delay alone is not strongly indicative of autism spectrum disorder unless there is also evidence of limited motivation for social communication and limited interaction skills. An essential feature of autism spectrum disorder is persistent impairment in the ability to understand and use language appropriately for social communication.

Repetitive and stereotyped behaviours

Many children go through phases of repetitive play and highly focused interests as a part of typical development. Unless there is also evidence of impaired reciprocal social interaction and social communication, patterns of behaviour characterized by repetition, routine or restricted interests are not by themselves indicative of autism spectrum disorder.

Course features

- Although autism spectrum disorder can present clinically at all ages, including during adulthood, it is a lifelong disorder, the manifestations and impact of which are likely to vary according to age, intellectual and language abilities, co-occurring conditions and environmental context.
- Restricted and repetitive behaviours persist over time. Specifically, repetitive sensorimotor behaviours appear to be common, consistent and potentially severe. During the school-age years and adolescence, these repetitive sensorimotor behaviours begin to lessen in intensity and number. Insistence on sameness, which is less prevalent, appears to develop during preschool and worsen over time.

Developmental presentations

Infancy

Characteristic features may emerge during infancy, although they may only be recognized as indicative of autism spectrum disorder in retrospect. It is usually possible to make the diagnosis of autism spectrum disorder during the preschool period (up to 4 years of age), especially in children exhibiting generalized developmental delay. Plateauing of social communication and language skills and failure to progress in their development is not uncommon. The loss of early words and social responsiveness – i.e. a true regression – with an onset between 1 and 2 years of age is unusual but significant, and rarely occurs after the third year of life. In these cases, the *with loss of previously acquired skills* specifier should be applied.

Preschool

In preschool-aged children, indicators of an autism spectrum disorder diagnosis often include avoidance of mutual eye contact, resistance to physical affection, a lack of social imaginary play, language that is delayed in onset or is precocious but not used for social conversation; social withdrawal, obsessive or repetitive preoccupations, and a lack of social interaction with peers characterized by parallel play or disinterest. Sensory sensitivities to everyday sounds, or to foods, may overshadow the underlying social communication deficits.

Middle childhood

In children with autism spectrum disorder without a disorder of intellectual development, social adjustment difficulties outside the home may not be detected until *middle childhood* (commonly at school entry) or during adolescence, when social communication problems lead to social isolation from peers. Resistance to engage in unfamiliar experiences and marked reactions to even minor change in routines are typical. Furthermore, excessive focus on detail and rigidity of behaviour and thinking may be significant. Symptoms of anxiety may become evident at this stage of development.

Adolescence

By adolescence, the capacity to cope with increasing social complexity in peer relationships at a time of increasingly demanding academic expectations is often overwhelmed. In some individuals with autism spectrum disorder, the underlying social communication deficits may be overshadowed by the symptoms of co-occurring mental and behavioural disorders. Depressive symptoms are often a presenting feature.

Adulthood

In adulthood, the capacity for those with autism spectrum disorder to cope with social relationships can become increasingly challenged, and clinical presentation may occur when social demands overwhelm the capacity to compensate. Presenting problems in adulthood may represent reactions to social isolation or the social consequences of inappropriate behaviour. Compensation strategies may be sufficient to sustain dyadic relationships, but are usually inadequate in social groups. Special interests, and focused attention, may benefit some individuals in education and employment. Work environments may have to be tailored to the capacities of the individual. A first diagnosis in adulthood may be precipitated by a breakdown in domestic or work relationships. In autism spectrum disorder there is always a history of early childhood social communication and relationship difficulties, although this may only be apparent in retrospect.

Culture-related features

- Cultural variation exists in norms of social communication and reciprocal social interactions, as well as interests and activities. Therefore, signs of impairment in functioning may differ depending on cultural context. For example, in some societies it may be normative for children may avoid direct eye contact out of deference, which should not be misinterpreted as impairment in social interaction.

Sex- and/or gender-related features

- Males are four times more likely than females to be diagnosed with autism spectrum disorder.
- Females diagnosed with autism spectrum disorder are more frequently diagnosed with co-occurring disorders of intellectual development than males, suggesting that less severe presentations may go undetected. Females tend to demonstrate fewer restricted, repetitive interests and behaviours.
- During middle childhood, gender differences in presentation differentially affect functioning. Boys may act out with reactive aggression or other behavioural symptoms when challenged or frustrated. Girls tend to withdraw socially, and react with emotional changes to their social adjustment difficulties.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Autism spectrum disorder may be diagnosed in individuals with disorders of intellectual development if deficits in initiating and sustaining social communication and reciprocal social interactions are greater than would be expected based on the individual's level of intellectual functioning, and if the other diagnostic requirements for autism spectrum disorder are also met. In these circumstances, both autism spectrum disorder and the disorder of intellectual development should be assigned, and the *with disorder of intellectual development* specifier should be applied with the autism spectrum disorder diagnosis. Because autism spectrum disorder inherently involves social deficits, assessment of adaptive behaviour as a part of the diagnosis of a co-occurring disorder of intellectual development should place greater emphasis on intellectual functioning and the conceptual and practical domains of adaptive functioning than on social skills. The diagnosis of autism spectrum disorder in individuals with severe and profound disorders of intellectual development is particularly difficult, and requires in-depth and longitudinal assessments. However, the diagnosis may be assigned if skills in social reciprocity and communication are significantly impaired relative to the individual's general level of intellectual ability.

Boundary with developmental language disorder with impairment of mainly pragmatic language

Individuals with developmental language disorder with impairment of mainly pragmatic language exhibit language deficits involving the ability to understand and use language in social contexts (i.e. with pragmatic language impairment). Unlike individuals with autism spectrum disorder, individuals with developmental language disorder are usually able to initiate and respond appropriately to social and emotional cues and to share interests with others, and do not typically exhibit restricted, repetitive and stereotyped behaviours. An additional diagnosis of developmental language disorder should not be assigned to individuals with autism spectrum disorder based solely on pragmatic language impairment. The other forms of developmental language disorder (i.e. with impairment of receptive and expressive language or with impairment of receptive and expressive language) may be assigned in conjunction with a diagnosis of autism spectrum disorder if language abilities are markedly below what would be expected based on age and level of intellectual functioning.

Boundary with developmental motor coordination disorder

Individuals with autism spectrum disorder may be reluctant to participate in tasks requiring complex motor coordination skills, such as ball sports, which is better accounted for by a lack of interest rather than any specific deficits in motor coordination. However, developmental motor coordination disorder and autism spectrum disorder can co-occur, and both diagnoses may be assigned if warranted.

Boundary with attention deficit hyperactivity disorder

Specific abnormalities in attention (e.g. being overly focused or easily distracted), impulsivity and physical hyperactivity are often observed in individuals with autism spectrum disorder. However, individuals with attention deficit hyperactivity disorder do not exhibit the persistent deficits in initiating and sustaining social communication and reciprocal social interactions or the persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are the defining features of autism spectrum disorder. However, autism spectrum disorder and attention deficit hyperactivity disorder can co-occur, and both diagnoses may be assigned if the diagnostic requirements for each are met. Attention deficit hyperactivity disorder symptoms may sometimes dominate the clinical presentation such that some autism spectrum disorder symptoms are less apparent.

Boundary with stereotyped movement disorder

Stereotyped movement disorder is characterized by voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period. Although such stereotyped movements are typical in autism spectrum disorder, if they are severe enough to require additional clinical attention – for example, because of self-injury – a co-occurring diagnosis of stereotyped movement disorder may be warranted.

Boundary with schizophrenia

The onset of schizophrenia may be associated with prominent social withdrawal, which is either preceded by or results in social impairments that may resemble social deficits seen in autism spectrum disorder. However, unlike autism spectrum disorder, the onset of schizophrenia is typically in adolescence or early adulthood, and is extremely rare prior to puberty. Schizophrenia is differentiated on the basis of the presence of psychotic symptoms (e.g. delusions, hallucinations), as well as a lack of restricted, repetitive and inflexible patterns of behaviour, interests or activities during early childhood typical of autism spectrum disorder.

Boundary with schizotypal disorder

Interpersonal difficulties seen in autism spectrum disorder may share some features of schizotypal disorder, such as poor rapport with others and social withdrawal. However, autism spectrum disorder is also characterized by restricted, repetitive and stereotyped patterns of behaviour, interests or activities.

Boundary with social anxiety disorder

Social anxiety disorder is associated with limited engagement in social interaction due to marked and excessive fear or anxiety about negatively evaluated by others. Typically, when interacting with familiar others or in social situations that do not provoke significant anxiety, there is no evidence of impairment. Individuals with autism spectrum disorder may experience social anxiety, but they also exhibit more pervasive deficits in initiating and sustaining social communication and reciprocal social interactions than are typically observed in social anxiety disorder. Persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities are not features of social anxiety disorder.

Boundary with selective mutism

Selective mutism is characterized by normal use of language and patterns of social communication in specific environments (such as the home), but not in others (such as at school). In autism spectrum disorder, a reluctance to communicate may be observed in some social circumstances, but deficits in initiating and sustaining social communication and reciprocal social interactions and persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities are evident across all situations and contexts.

Boundary with obsessive-compulsive disorder

Obsessive-compulsive disorder is characterized by persistent repetitive thoughts, images, or impulses/urges (i.e. obsessions) and/or repetitive behaviours (i.e. compulsions) that the individual feels driven to perform in response to an obsession, according to rigid rules, to reduce anxiety or to achieve a sense of "completeness". These symptoms may be difficult to distinguish from restricted, repetitive and inflexible patterns of behaviour, interests or activities that are characteristic of autism spectrum disorder. Unlike those with autism spectrum disorder, it is more common for individuals with obsessive-compulsive disorder consciously to resist their impulsive urges to perform compulsive behaviours (e.g. by performing alternate tasks), though adolescents and adults with autism spectrum disorder may also try to suppress specific behaviours that they realize are socially undesirable. Autism spectrum disorder can also be distinguished from obsessive-compulsive disorder by its characteristic deficits in initiating and sustaining social communication and reciprocal social interactions, which are not features of obsessive-compulsive disorder.

Boundary with reactive attachment disorder

Reactive attachment disorder is characterized by inhibited emotionally withdrawn behaviour exhibited towards adult caregivers, including a failure to approach a discriminated, preferred attachment figure for comfort, support, protection or nurturance. The diagnosis of reactive attachment disorder requires evidence of a history of severe neglect or maltreatment by the primary caregiver or other forms of severe social deprivation (e.g. certain types of institutionalization). Some individuals reared under conditions of severe deprivation in institutional settings exhibit autistic-like features, including difficulties in social reciprocity and restricted, repetitive and inflexible patterns of behaviour, interests or activities. Also referred to as "quasi-autism", affected individuals are differentiated from those with autism spectrum disorder based on significant improvement of autism-like features when the child is moved to a more nurturing environment. Differentiation between reactive attachment disorder and autism spectrum disorder is difficult when no reliable evidence is available of intact social and communicative development prior to the onset of abuse or neglect.

Boundary with disinhibited social engagement disorder

Disinhibited social engagement disorder is characterized by persistent indiscriminate social approaches to unfamiliar adults and peers, a pattern of behaviour that may also be seen in some children with autism spectrum disorder. The diagnosis of disinhibited social engagement disorder requires evidence of a history of severe neglect or maltreatment by the primary caregiver or other forms of severe social deprivation (e.g. certain types of institutionalization). As in reactive attachment

disorder, disinhibited social engagement disorder may be associated with generalized deficits in social understanding and social communication. Although they may occur, restricted, repetitive and inflexible patterns of behaviour, interests or activities are not typical features of disinhibited social engagement disorder. Evidence of a significant reduction in symptoms when the child is provided a more nurturing environment suggests that disinhibited social engagement disorder is the appropriate diagnosis.

Boundary with avoidant-restrictive food intake disorder

Individuals with avoidant-restrictive food intake disorder sometimes restrict their food intake based on food's sensory characteristics such as smell, taste, temperature, texture or appearance. Individuals with autism spectrum disorder may also restrict intake of certain foods because of their sensory characteristics or because of inflexible adherence to particular routines. However, autism spectrum disorder is also characterized by persistent deficits in initiating and sustaining social communication and reciprocal social interactions and persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are unrelated to food. If a pattern of restricted eating in an individual with autism spectrum disorder has caused significant weight loss or other health consequences, or is specifically associated with significant functional impairment, an additional diagnosis of avoidant-restrictive food intake disorder may be assigned.

Boundary with oppositional defiant disorder

Oppositional defiant disorder is characterized by a pattern of markedly noncompliant, defiant and disobedient disruptive behaviour that is not typical for individuals of comparable age and developmental level. Individuals with oppositional defiant disorder do not exhibit the social communication deficits or restricted, repetitive and inflexible patterns of behaviour, interests or activities that are characteristic of autism spectrum disorder. However, oppositional or "demand avoidant" behaviour may be prominent in some children with autism spectrum disorder, whether or not they have accompanying intellectual or functional language impairments, and may sometimes be the presenting feature in school-aged children with autism spectrum disorder. Disruptive behaviour with aggressive outbursts (explosive rages) may also be a prominent feature of autism spectrum disorder. Among individuals with autism spectrum disorder, such outbursts are often associated with a specific trigger (e.g. a change in routine, aversive sensory stimulation, anxiety or rigidity when the individual's thoughts or behaviour sequences are interrupted) rather than reflecting an intention to be defiant, provocative or spiteful, as is more typical of oppositional defiant disorder.

Boundary with personality disorder

Personality disorder is a pervasive disturbance in how an individual experiences and thinks about the self, others and the world, manifested in maladaptive patterns of cognition, emotional experience, emotional expression and behaviour. The maladaptive patterns are relatively inflexible, manifesting across a range of personal and social situations; relatively stable over time; and of long duration. They are associated with significant problems in psychosocial functioning that are particularly evident in interpersonal relationships. The difficulties some individuals with autism spectrum disorder exhibit in initiating and maintaining relationships because of their limited skills in social communication and reciprocal social interactions may resemble those seen in some individuals with personality disorder. However, unlike autism spectrum disorder, persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities with onset in early childhood are not characteristic features of personality disorder.

Boundary with primary tics and tic disorders including Tourette syndrome

Sudden, rapid, non-rhythmic and recurrent movements or vocalizations occur in primary tics and tic disorders, which may resemble repetitive and stereotyped motor movements in autism spectrum disorder. Unlike autism spectrum disorder, tics in primary tics and tic disorders tend to be less stereotyped, are often accompanied by premonitory sensory urges, last for a shorter period, tend to emerge later in life, and are not experienced by the individual as soothing.

Boundary with diseases of the nervous system and other medical conditions classified elsewhere

Loss of previously acquired skills in language and social communication in the second year of life is reported in some children with autism spectrum disorder, but this rarely occurs after the age of 3 years. Diseases of the nervous system and other medical conditions associated with regression (e.g. acquired epileptic aphasia or Landau-Kleffner syndrome, autoimmune encephalitis, Rett syndrome) are differentiated from autism spectrum disorder with loss of previously acquired skills on the basis of an early history of relatively normal social and language development, and by the characteristic neurological features of these disorders that are not typical of autism spectrum disorder.

Boundary with secondary neurodevelopmental syndrome

Autistic features may become manifest in the context of acquired medical conditions, such as encephalitis. Identifying accurately whether the symptoms are secondary to another medical condition or represent the exacerbation of pre-existing autism spectrum disorder may have implications for both immediate management and prognosis. When autistic symptoms are attributable to another medical condition, a diagnosis of secondary neurodevelopmental syndrome rather than autism spectrum disorder may be assigned.

6A03 Developmental learning disorder

Essential (required) features

- The presence of significant limitations in learning academic skills of reading, writing or arithmetic, resulting in a skill level markedly below what would be expected based on age is required for diagnosis. Limitations in learning are manifest, despite appropriate academic instruction in the relevant areas. The limitations may be restricted to a single component of a skill (e.g. an inability to master basic numeracy, or to decode single words accurately and fluently) or may affect all reading, writing and arithmetic. Ideally, limitations are measured using appropriately normed and standardized tests.
- Onset of the limitations typically occurs during the early school years, but in some individuals may not be identified until later in life, including into adulthood, when performance demands related to learning exceed limited capacities.
- The limitations are not attributable to external factors, such as economic or environmental disadvantage, or lack of access to educational opportunities.
- The learning difficulties are not better accounted for by a disorder of intellectual development or another neurodevelopmental disorder, or by another condition such as a motor disorder or a sensory disorder of vision or hearing.
- The learning difficulties result in significant impairment in the individual's academic, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Specifiers for area of learning impairment

Specifiers should be applied to indicate which academic skills are significantly impaired at the time of assessment. Multiple specifiers may be used to reflect limitations in multiple skills.

6A03.0 Impairment in reading

- Learning difficulties are manifested in impairments in reading skills such as word reading accuracy, reading fluency or reading comprehension.

6A03.1 Impairment in written expression

- Learning difficulties are manifested in impairments in writing skills such as spelling accuracy, grammar and punctuation accuracy, or organization and cohesion of ideas in writing.

6A03.2 Impairment in mathematics

- Learning difficulties are manifested in impairments in mathematical skills such as number sense, memorization of number facts, accurate calculation, fluent calculation or accurate mathematic reasoning.

6A03.3 Other specified impairment of learning

- Learning difficulties are manifested in impairments in learning and performance of specific academic skills that are not adequately characterized by one of the other available specifiers.

6A03.Z Developmental learning disorder, unspecified

Additional clinical features

- Individuals with developmental learning disorder typically show impairments in various underlying psychological processes that may include phonological processing, orthographic processing, memory (including working memory), executive functions (including inhibitory control, set-shifting, planning), learning and automatizing symbols (e.g. visual, alphanumeric), perceptual-motor integration and speed of processing information. Deficits in these psychological processes are presumed to underlie a child's ability to learn academic skills. However, the precise relationship between psychological processes and outcomes related to learning capacity is not yet sufficiently understood to allow an accurate and clinically useful classification based on these underlying processes.
- Developmental learning disorder commonly co-occurs with other neurodevelopmental disorders, such as attention deficit hyperactivity disorder, developmental motor coordination disorder, developmental language disorder and autism spectrum disorder.
- Many individuals with developmental learning disorder have marked difficulties self-regulating attention that are not sufficiently severe to warrant a separate diagnosis. Persistent difficulties with self-regulated attention can have deleterious effects on academic outcomes, and may impede response to intervention or support.
- Some individuals with developmental learning disorder may be able to sustain seemingly adequate levels of key academic skills by using compensatory strategies or through devoting extraordinarily high levels of effort or time, or through the provision of unusually high levels of support. However, as demands for efficiency in key academic skills increase and exceed capabilities (e.g. in timed tests, reading or writing lengthy detailed reports for a tight deadline, heavier academic coursework as in high school/secondary school, postsecondary education or professional training), the underlying learning difficulties tend to become more fully apparent.
- Ideally, determination of the presence of developmental learning disorder includes assessment of academic achievement using standardized, appropriately normed instruments. However, a child's score on a single test measuring a particular academic skill is not sufficient to distinguish disorder from normality. Achievement scores may vary as a result of the technical properties of the specific test being used, the testing conditions and a variety of other variables, and also can vary substantially over the individual's development and life-course. Therefore, the diagnosis of developmental learning disorder should also consider various sources of evidence regarding the child's capacity for learning outside the formal testing situation.

Boundary with normality (threshold)

- The age of acquisition of academic skills varies, and later acquisition of a particular academic skill compared to same-age peers does not necessarily indicate the presence of a disorder. Developmental learning disorder is distinguished by persistent difficulty in learning the particular academic skills over time in spite of adequate educational opportunities, and by the severity of the impairment caused by the learning difficulty.

Course features

- Deficits in reading, mathematics and written expression identified in childhood typically persist through adolescence and into adulthood. These deficits may negatively affect a child's academic achievement, increase the likelihood of school dropout, and contribute to unemployment (or underemployment) in adulthood – particularly if left untreated. Along with school dropout, significant co-occurring depressive symptoms increase the risk of poor mental health outcomes, including suicide.
- The specific impairments associated with developmental learning disorder vary with developmental stage and learning abilities, severity of deficits, complexity of tasks, presence of co-occurring mental, behavioural and neurodevelopmental disorders, and the availability of support.
- Developmental learning disorder is also associated with heightened risk of suicidal ideation and suicide attempts across the lifespan.

Developmental presentations

- Developmental learning disorder is most often diagnosed during elementary school years because difficulties in reading, mathematics and/or writing typically only become evident when these topics are taught formally. Some individuals, however, may not be diagnosed until later in development, including in adulthood. Premorbid impairments, such as in language, counting or rhyming, or fine motor control tend to be evident in early childhood prior to the diagnosis of developmental learning disorder.
- The prevalence of developmental learning disorder across all areas of impairment (i.e. reading, written expression and mathematics) is estimated to affect between 5% and 15% of school-aged children. Prevalence among adults is unknown, but is estimated at approximately 4%. The prevalence of developmental learning disorder for specific academic areas among school-aged children is variable (reading is estimated at 5–17%; mathematics at 6–7%; written expression at 7–15%).
- Children with developmental learning disorder frequently exhibit co-occurring symptoms of depressive disorders, anxiety and fear-related disorders, and externalizing behaviour disorders, which may make it more difficult to assess their learning impairments.
- Children with developmental learning disorder with impairment in one academic area are more likely to have co-occurring impairments in other areas.

Culture-related features

- Developmental learning disorder with impairment in reading can be manifested differently by language. For example, in English, the presentation involves inaccurate and slow reading of single words. In other languages with more direct mapping between sounds and letters (e.g. Spanish, German) and non-alphabetic languages (e.g. Chinese, Japanese), the typical presentation is slow but accurate reading.

Sex- and/or gender-related features

- Developmental learning disorder is more common among boys. Boys may be more likely to be clinically referred because of greater prevalence of co-occurring attention deficit hyperactivity disorder or problematic externalizing behaviours.
- Among community samples, the gender ratio of males to females ranges from 1.5:1 to 3:1. This ratio appears greater in clinical samples (estimated at 6:1).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Individuals with disorders of intellectual development often present with limitations in academic achievement by virtue of significant generalized deficits in intellectual functioning. It is therefore difficult to establish the co-occurring presence of a developmental learning disorder in individuals with a disorder of intellectual development. Developmental learning disorder should only be diagnosed in the presence of a disorder of intellectual development when the limitations in learning are significantly in excess of those usually expected for the individual's level of intellectual functioning.

Boundary with developmental language disorder

Persistent deficits in the acquisition, understanding, production or use of language in developmental language disorder may lead to academic learning difficulties, especially in literacy – including word reading and written output. If all diagnostic requirements for both developmental language disorder and developmental learning disorder are met, both diagnoses may be assigned.

Boundary with attention deficit hyperactivity disorder

Many individuals with developmental learning disorder have marked difficulties in self-regulating attention. However, unlike in attention deficit hyperactivity disorder, the limitations in acquisition of academic skills in developmental learning disorder are not solely a function of a child's ability to sustain attention on academic tasks or modulate their activity level appropriately. The co-occurrence of developmental learning disorder and attention deficit hyperactivity disorder is common, and both disorders may be diagnosed if diagnostic requirements are met.

Boundary with sensory impairments

Developmental learning disorder must be differentiated from learning difficulties that arise because of sensory impairments in vision or hearing. However, individuals with vision and hearing problems for which appropriate accommodations have been made may also have co-occurring developmental learning disorder.

Boundary with neurodegenerative diseases

Developmental learning disorder is distinguished from learning difficulties that occur after the developmental period due to neurodegenerative diseases or to injury (e.g. traumatic brain injury) by the fact that in the latter conditions there is a loss of previously acquired academic skills and previous capacity for learning new skills.

6A04 Developmental motor coordination disorder

Essential (required) features

- Significant delay in the acquisition of gross or fine motor skills and impairment in the execution of coordinated motor skills manifesting as clumsiness, slowness or inaccuracy of motor performance is required for diagnosis.
- Coordinated motor skills are markedly below those expected on the basis of age.
- Onset of coordinated motor skill difficulties occurs during the developmental period, and is typically apparent from early childhood.
- Coordinated motor skills difficulties cause significant and persistent limitations in activities of daily living, schoolwork, vocation and leisure activities, or other important areas of functioning.
- Difficulties with coordinated motor skills are not better accounted for by a disease of the nervous system, disease of the musculoskeletal system or connective tissue, sensory impairment or a disorder of intellectual development.

Additional clinical features

- Young children with developmental motor coordination disorder may be delayed in achieving motor milestones (e.g. sitting, crawling, walking), although many achieve typical early motor milestones. Acquisition of skills such as negotiating stairs, pedalling, buttoning shirts, completing puzzles, tying shoes and using zippers may be delayed or pose difficulties. Even when a given skill is achieved, movement execution may appear awkward, slow or less precise than that of peers. Children may drop things, stumble, bump into obstacles or fall more frequently than peers.
- Developmental motor coordination disorder may affect primarily gross motor functioning, primarily fine motor functioning or both aspects of motor functioning.
- Manifestations of developmental motor coordination disorder typically persist into adult life. Older children and adults with developmental motor coordination disorder may be slow or inaccurate in a variety of activities requiring fine or gross motor skills, such as team sports (especially ball sports), bicycling, handwriting, assembling models or other objects, or drawing maps.
- Other neurodevelopmental disorders commonly co-occur with developmental motor coordination disorder. In addition to disorders of intellectual development, attention deficit hyperactivity disorder and autism spectrum disorder, this also includes developmental speech sound disorder (particularly difficulties with articulation), developmental language disorder and developmental learning disorder. Although the presence of other neurodevelopmental disorders does not preclude the diagnosis of developmental motor coordination disorder, these disorders may also interfere with the execution of activities

of daily living, schoolwork, and vocational and leisure activities that require coordinated motor skills. Co-occurrence therefore complicates assessment and requires clinical judgement in attributing limitations in activities that require coordinated motor skills to a specific diagnosis.

Boundary with normality (threshold)

- There is considerable variation in the age of acquisition of many motor skills and a lack of stability of measurement in early childhood. Onset of developmental motor coordination disorder typically occurs during the early developmental period, but differentiation from typical development before the age of 4 years is difficult due to the variability in motor development and skill acquisition throughout early childhood. Therefore, the diagnosis of developmental motor coordination disorder is usually not made before the age of 5 years.
- Performance of motor skills should ideally be assessed using appropriately normed, individually administered, culturally appropriate standardized tests of gross and fine motor coordination, and should include evaluation of the impact of symptoms at home and at school (or, in adults, in the workplace). Key features for assessment are persistence of motor skill impairment over time, severity of impairment and pervasiveness of impact on functioning.
- Developmental motor coordination disorder often co-occurs with other neurodevelopmental disorders. Attention deficit hyperactivity disorder is most common (an estimated 50% of cases). Developmental speech and language disorder, developmental learning disorder (most often with impairments in reading and written expression) and autism spectrum disorder also commonly co-occur with developmental motor coordination disorder.

Course features

- Though there may be improvement in symptoms over time, with some children experiencing a complete remission of symptoms, the course of developmental motor coordination disorder is typically chronic, persisting into adolescence and adulthood in up to 50–70% of cases. The persistence of developmental motor coordination disorder into adulthood often affects social and psychological functioning as well as physical health.
- The presence of other co-occurring neurodevelopmental disorders, such as attention deficit hyperactivity disorder, may further complicate the course of developmental motor coordination disorder. Individuals with co-occurring disorders typically experience more impairment than individuals with a single diagnosis.

Developmental presentations

- The prevalence of developmental motor coordination disorder is approximately 5–6% of children aged 5–11 years, although up to 10% of children may have less severe difficulties with motor skills that still affect academic and social functioning.
- The manifestation of developmental motor coordination disorder symptoms varies with developmental stage.

  ### Preschool

  In preschool-aged children, delays in meeting one or more motor milestones (e.g. sitting, crawling, walking) or in developing specific skills (e.g. climbing stairs, buttoning clothing, tying shoes) may be evident.

  ### Middle childhood

  In middle childhood, symptoms may be evident in activities such as handwriting, playing with a ball, or building puzzles or models.

  ### Adolescence and adulthood

  By adolescence *and adulthood,* difficulties in motor coordination may manifest in attempts to master new skills, such as driving, using tools or note taking.

  ### All developmental stages

  Across all developmental stages, even once a skill is acquired, the execution of movements tends to be more awkward and less precise than in typically developing peers.

- Children with developmental motor coordination disorder may also be at increased risk of co-occurring disruptive behaviour problems, anxiety and depression. In addition, children with developmental motor coordination disorder tend to report lower levels of self-efficacy and competence in physical and social abilities, and are at heightened risk of becoming overweight or obese compared to their typically developing peers.

Sex- and/or gender-related features

- Developmental motor coordination disorder more frequently affects boys, with a ratio of boys to girls of between 2:1 and 7:1.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Individuals with disorders of intellectual development may exhibit delays in acquisition and impairment in the execution of coordinated motor skills, along with deficits in general intellectual

functioning and adaptive behaviour. If the diagnostic requirements of a disorder of intellectual development are met, and coordinated motor skills are significantly below what would be expected based on level of intellectual functioning and adaptive behaviour, both diagnoses may be assigned.

Boundary with autism spectrum disorder

In autism spectrum disorder, there may be reluctance to participate in tasks requiring complex motor coordination skills, such as ball sports, which is better accounted for by a lack of interest rather than any specific deficits in motor coordination.

Boundary with attention deficit hyperactivity disorder

Co-occurrence of developmental motor coordination disorder and attention deficit hyperactivity disorder is common. Both diagnoses may be assigned if the diagnostic requirements for each are met. However, some individuals with attention deficit hyperactivity disorder may appear to be clumsy (e.g. bumping into obstacles, knocking things over) due to distractibility and impulsivity. Developmental motor coordination disorder should not be diagnosed in such cases.

Boundary with diseases of the nervous system, diseases of the musculoskeletal system or connective tissue, and sensory impairment

Motor skills may be affected by diseases of the nervous system (e.g. cerebral palsy, muscular dystrophy), diseases of the musculoskeletal system or connective tissue, sensory impairment (especially severe visual impairment) or joint hypermobility, which are established by appropriate physical and laboratory examination. A diagnosis of developmental motor coordination disorder should not be assigned when the difficulties with motor coordination are solely attributable to one of these conditions. Some children with developmental motor coordination disorder show atypical motor activity (usually suppressed), such as choreiform movements of unsupported limbs or mirror movements.[5] These "overflow" movements are not considered diseases of the nervous system *per se,* and do not exclude the diagnosis of developmental motor coordination disorder.

Boundary with effects of psychosocial deprivation

Extreme psychosocial deprivation in early childhood can produce impairments in motor functions. Depending on the onset, level of severity and duration of the deprivation, motor functioning may improve substantially after the child is moved to a more positive environment. However, some deficits may persist even after a sustained period in an environment that provides adequate stimulation for development, and a diagnosis of developmental motor coordination disorder may be appropriate in such cases if all diagnostic requirements are met.

6A05 Attention deficit hyperactivity disorder

Essential (required) features

- A persistent pattern (e.g. over at least 6 months) of inattention symptoms and/or a combination of hyperactivity and impulsivity symptoms that is outside the limits of normal variation expected for age and level of intellectual development is required for diagnosis. Symptoms vary according to chronological age and disorder severity.

5 Chorieform movements are involuntary, irregular and unpredictable movements that make it appear as if the affected person is dancing, twisting, restless, clumsy or fidgety.

Inattention

Several symptoms of inattention that are persistent and sufficiently severe that they have a direct negative impact on academic, occupational or social functioning are among the essential components. Symptoms are typically from the following clusters:

- having difficulty sustaining attention on tasks that do not provide a high level of stimulation or reward or require sustained mental effort; lacking attention to detail; making careless mistakes in school or work assignments; not completing tasks;
- being easily distracted by extraneous stimuli or thoughts not related to the task at hand; often seeming not to listen when spoken to directly; frequently appearing to be daydreaming or to have their mind elsewhere;
- losing things; being forgetful in daily activities; having difficulty remembering to complete upcoming daily tasks or activities; having difficulty planning, managing and organizing schoolwork, tasks and other activities.

Note: inattention may not be evident when the individual is engaged in activities that provide intense stimulation and frequent rewards.

Hyperactivity-impulsivity

Several symptoms of hyperactivity-impulsivity that are persistent and sufficiently severe that they have a direct negative impact on academic, occupational or social functioning are among the essential components. These tend to be most evident in structured situations that require behavioural self-control. Symptoms are typically from the following clusters:

- showing excessive motor activity; leaving their seat when expected to sit still; often running about; having difficulty sitting still without fidgeting (younger children); displaying feelings of physical restlessness and a sense of discomfort with being quiet or sitting still (adolescents and adults);
- having difficulty engaging in activities quietly; talking too much;
- blurting out answers in school or comments at work; having difficulty waiting their turn in conversation, games or activities; interrupting or intruding on others' conversations or games;
- having a tendency to act in response to immediate stimuli without deliberation or consideration of risks and consequences (e.g. engaging in behaviours with potential for physical injury; impulsive decisions; reckless driving).

- Evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12, though some individuals may first come to clinical attention later in adolescence or as adults, often when demands exceed the individual's capacity to compensate for limitations.
- Manifestations of inattention and/or hyperactivity-impulsivity must be evident across multiple situations or settings (e.g. home, school, work, with friends or relatives), but are likely to vary according to the structure and demands of the setting.
- Symptoms are not better accounted for by another mental disorder (e.g. an anxiety or fear-related disorder, a neurocognitive disorder such as delirium).
- Symptoms are not due to the effects of a substance (e.g. cocaine) or medication (e.g. bronchodilators, thyroid replacement medication) on the central nervous system, including and withdrawal effects, and are not due to a disease of the nervous system.

Specifiers to describe predominant characteristics of clinical presentation

- The characteristics of the current clinical presentation should be described using one of the following specifiers, which are meant to assist in recording the main reason for the current referral or services. Predominance of symptoms refers to the presence of several symptoms of either an inattentive or hyperactive-impulsive nature, with few or no symptoms of the other type.

6A05.0 Attention deficit hyperactivity disorder, predominantly inattentive presentation

- All diagnostic requirements for attention deficit hyperactivity disorder are met, and inattentive symptoms predominate.

6A05.1 Attention deficit hyperactivity disorder, predominantly hyperactive-impulsive presentation

- All diagnostic requirements for attention deficit hyperactivity disorder are met, and symptoms of hyperactivity-impulsivity predominate.

6A05.2 Attention deficit hyperactivity disorder, combined presentation

- All diagnostic requirements for attention deficit hyperactivity disorder are met, and both hyperactive-impulsive and inattentive symptoms are clinically significant aspects of the current clinical presentation, with neither clearly predominating.

6A05.Y Attention deficit hyperactivity disorder, other specified presentation

6A05.Z Attention deficit hyperactivity disorder, presentation unspecified

Additional clinical features

- Attention deficit hyperactivity disorder usually manifests in early or middle childhood. In many cases, hyperactivity symptoms predominate in preschool and decrease with age, such that they are no longer prominent beyond adolescence or may instead be reported as feelings of physical restlessness. Attentional problems may be more commonly observed beginning in later childhood, especially in school and among adults in occupational settings.
- The manifestations and severity of attention deficit hyperactivity disorder often vary according to the characteristics and demands of the environment. Symptoms and behaviours should be evaluated across multiple types of environments as a part of clinical assessment.
- Where available, teacher and parent reports should be obtained to establish the diagnosis in children and adolescents. In adults, the report of a significant other, family member or co-worker can provide important additional information.
- Some individuals with attention deficit hyperactivity disorder may first present for services in adulthood. When making the diagnosis of attention deficit hyperactivity disorder in adults, a history of inattention, hyperactivity or impulsivity before 12 years of age is an important corroborating feature that can be best established from school or local records, or from informants who knew the individual during childhood. In the absence of such corroborating information, a diagnosis of attention deficit hyperactivity disorder in older adolescents and adults should be made with caution.
- In a subset of individuals with attention deficit hyperactivity disorder, especially in children, an exclusively inattentive presentation may occur. There is no hyperactivity, and the presentation is characterized by daydreaming, mind-wandering and a lack of focus. These children are sometimes referred to as exhibiting a "restrictive inattentive pattern of symptoms" or "sluggish cognitive tempo".
- In a subset of individuals with attention deficit hyperactivity disorder, combined presentation, severe inattentiveness and hyperactivity-impulsivity are both consistently present in most of the situations that an individual encounters, and are also evidenced by the clinician's own observations. This pattern is often referred to as "hyperkinetic disorder", and is considered a more severe form of the disorder.
- Attention deficit hyperactivity disorder symptoms often significantly limit academic achievement. Adults with attention deficit hyperactivity disorder often find it difficult to hold down a demanding job, and may be disproportionately underemployed or unemployed. Attention deficit hyperactivity disorder can also strain interpersonal relationships across the lifespan, including those with family members, peers and romantic partners. Individuals with attention deficit hyperactivity disorder often have greater difficulty regulating their behaviour in the context of groups than in one-on-one situations.
- Attention deficit hyperactivity disorder often co-occurs with other neurodevelopmental disorders, including developmental speech and language disorders and primary tics and tic disorders, which are classified in Chapter 8 on diseases of the nervous system but cross-listed under neurodevelopment disorders. Attention deficit hyperactivity disorder is associated with an increased risk of obsessive-compulsive disorder and gaming disorder, and with elevated rates of epilepsy. Emotional dysregulation, low frustration tolerance and subtle clumsiness and other minor ("soft") neurological abnormalities in sensory and motor performance in the absence of any identifiable brain pathology are also common in attention deficit hyperactivity disorder.

- Attention deficit hyperactivity disorder is associated with an increased risk of physical health problems including accidents.
- Acute onset of hyperactive behaviour in a school-aged child or adolescent should raise the possibility that symptoms are better accounted for by another mental disorder or by a medical condition. For example, abrupt onset of hyperactivity in adolescence or adulthood may indicate an emergent primary psychotic or bipolar disorder.
- Although attention deficit hyperactivity disorder tends to run in families, with evidence of high heritability, the predominant symptom pattern in attention deficit hyperactivity disorder in a given individual often changes over time and cannot be predicted based on the predominant symptoms of other family members.

Boundary with normality (threshold)

- Inattention, hyperactivity and impulsivity symptoms are present in many children, adolescents and adults, especially during certain developmental periods (e.g. early childhood). The diagnosis of attention deficit hyperactivity disorder requires that these symptoms be persistent across time, pervasive across situations and significantly out of keeping with developmental level, and have a direct negative impact on academic, occupational or social functioning.

Course features

- Nearly half of all children diagnosed with attention deficit hyperactivity disorder will continue to exhibit symptoms into adolescence. Predictors of persistence into adolescence and adulthood include co-occurring childhood-onset mental, behavioural and neurodevelopmental disorders, lower intellectual functioning, poorer social functioning and behavioural problems.
- Attention deficit hyperactivity disorder symptoms tend to remain stable throughout adolescence, with approximately one third of individuals diagnosed in childhood continuing to experience impairment in adulthood.
- Although symptoms of hyperactivity become less overt during adolescence and adulthood, individuals may still experience difficulties with inattention, impulsivity and restlessness.

Developmental presentations

- Adolescents and adults may only seek clinical services after 12 years of age, once symptoms become more limiting with increasing social, emotional and academic demands or in the context of an evolving co-occurring mental, behavioural or neurodevelopmental disorder that results in an exacerbation of attention deficit hyperactivity disorder symptoms.

Culture-related features

- The symptoms of attention deficit hyperactivity disorder consistently fall into two separate dimensions across cultures: inattention and hyperactivity-impulsivity. However, culture can influence both acceptability of symptoms and how caregivers respond to them.
- The assessment of hyperactivity should take into account cultural norms of age and gender-appropriate behaviour. For example, in some countries hyperactive behaviour may be seen as a sign of strength in a boy (e.g. "boiling blood") while being perceived very negatively in a girl.
- Symptoms of inattention or hyperactivity-impulsivity may occur in response to exposure to traumatic events and grief reactions during childhood, particularly in highly vulnerable and disadvantaged populations, including in post-conflict areas. In these settings, clinicians should consider whether the diagnosis of attention deficit hyperactivity disorder is warranted.

Sex- and/or gender-related features

- Attention deficit hyperactivity disorder is more prevalent among males.
- Females are more likely to exhibit inattentive symptoms whereas males are more likely to exhibit symptoms of hyperactivity and impulsivity, particularly at younger ages.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with disorders of intellectual development

Co-occurrence of attention deficit hyperactivity disorder and disorders of intellectual development is common, and both diagnoses may be assigned if warranted. However, symptoms of inattention and hyperactivity (e.g. restlessness) are common in children without attention deficit hyperactivity disorder who are placed in academic settings that are out of keeping with their intellectual abilities. A diagnosis of attention deficit hyperactivity disorder in individuals with disorders of intellectual development requires that attention deficit hyperactivity disorder symptoms are disproportionate to the individual's level of intellectual functioning.

Boundary with autism spectrum disorder

Specific abnormalities in attention (e.g. being overly focused or easily distracted), impulsivity and physical hyperactivity are often observed in individuals with autism spectrum disorder, and may sometimes dominate the clinical presentation. Unlike individuals with autism spectrum disorder, those with attention deficit hyperactivity disorder do not exhibit the persistent deficits in initiating and sustaining social communication and reciprocal social interactions, or the persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are the defining features of autism spectrum disorder. However, co-occurrence of these disorders is common.

Boundary with developmental learning disorder

Individuals with developmental learning disorder without attention deficit hyperactivity disorder may exhibit symptoms of inattention and hyperactivity when asked to focus on specific academic activities that correspond to their areas of difficulty (i.e. reading, mathematics or writing). If difficulty in sustaining attention on academic tasks or appropriately modulating activity level occurs only in response to these tasks, and there is evidence of limitations in acquisition of academic skills in the specific corresponding area, a diagnosis of developmental learning disorder and not attention deficit hyperactivity disorder should be assigned.

Boundary with developmental motor coordination disorder

Co-occurrence of attention deficit hyperactivity disorder and developmental motor coordination disorder is common, and both diagnoses may be assigned if warranted. However, apparent clumsiness in some individuals with attention deficit hyperactivity disorder (e.g. bumping into obstacles, knocking things over) that is due to distractibility and impulsivity should not be diagnosed as developmental motor coordination disorder.

Boundary with mood disorders and anxiety and fear-related disorders

Attention deficit hyperactivity disorder can co-occur with mood disorders and anxiety and fear-related disorders, but inattention, hyperactivity and impulsivity can also be features of these disorders in individuals without attention deficit hyperactivity disorder. For example, symptoms such as restlessness, pacing and impaired concentration can be features of a depressive episode, and should not be considered as part of the diagnosis of attention deficit hyperactivity disorder unless they have been present since childhood and persist after the resolution of the depressive episode. Inattention, impulsivity and hyperactivity are typical features of manic and hypomanic episodes. At the same time, mood lability and irritability may be associated features of attention deficit hyperactivity disorder. Late adolescent or adult onset, episodicity and intensity of mood elevation characteristic of bipolar disorders are features that assist in differentiation from attention deficit hyperactivity disorder. Fidgeting, restlessness and tension in the context of anxiety and fear-related disorders may resemble hyperactivity. Furthermore, anxious preoccupations or reaction to anxiety-provoking stimuli in individuals with anxiety and fear-related disorders can be associated with difficulties concentrating. To qualify for an attention deficit hyperactivity disorder diagnosis in the presence of a mood disorder or an anxiety or fear-related disorder, inattention and/or hyperactivity should not be exclusively associated with mood episodes, be solely attributable to anxious preoccupations, or occur specifically in response to anxiety-provoking situations.

Boundary with intermittent explosive disorder

Attention deficit hyperactivity disorder and intermittent explosive disorder are both characterized by impulsive behaviour. However, intermittent explosive disorder is specifically characterized by intermittent severe impulsive outbursts or aggression rather than ongoing generalized behavioural impulsivity that may be seen in attention deficit hyperactivity disorder.

Boundary with oppositional defiant disorder

Individuals with attention deficit hyperactivity disorder often have difficulty following instructions, complying with rules and getting along with others, but these difficulties are primarily accounted for by symptoms of inattention and/or hyperactivity and impulsivity (e.g. failure to follow long and complicated instructions, difficulty remaining seated or staying on task). In contrast, noncompliance in individuals with oppositional defiant disorder is characterized by deliberate defiance or disobedience and not by problems with inattention or with controlling behavioural impulses or inhibiting inappropriate behaviours. However, co-occurrence of these disorders is common.

Boundary with conduct-dissocial disorder

In adolescents and adults with attention deficit hyperactivity disorder, some behaviours that are manifestations of impulsivity such as grabbing objects, reckless driving or impulsive decision-making – such as suddenly walking out of jobs or relationships – may bring the individual in conflict with

other people and the law. In contrast, individuals with conduct-dissocial disorder typically lack the symptoms of inattention and hyperactivity, and exhibit a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms, rules or laws are violated. However, co-occurrence of these disorders is common.

Boundary with personality disorder

Individuals with attention deficit hyperactivity disorder often experience problems with psychosocial functioning and interpersonal relationships, including regulation of emotions and negative emotionality. If attention deficit hyperactivity disorder persists into adolescence and adulthood, it may be difficult to distinguish from personality disorder with prominent personality features of disinhibition, which includes irresponsibility, impulsivity, distractibility and recklessness, and from negative affectivity, which refers to a habitual tendency to manifest a broad range of distressing emotions including anxiety, anger, self-loathing, irritability and increased sensitivity to negative stimuli. The utility of assigning an additional diagnosis of personality disorder in situations where there is an established diagnosis of attention deficit hyperactivity disorder depends on the specific clinical situation.

Boundary with disorders due to substance use and the effects of certain prescribed medications

Abuse of alcohol, nicotine, cannabis and stimulants is common among individuals with attention deficit hyperactivity disorder – particularly adolescents and adults. However, the effects of these substances can also mimic the symptoms of attention deficit hyperactivity disorder in individuals without the diagnosis. Symptoms of inattention, hyperactivity or impulsivity are also associated with the effects of certain prescribed medications (e.g. anticonvulsants such as carbamazepine and valproate, antipsychotics such as risperidone, and somatic treatments such as bronchodilators and thyroid replacement medication). The temporal order of onset and the persistence of inattention, hyperactivity and impulsivity in the absence of intoxication or continued medication use are important in differentiating between attention deficit hyperactivity disorder and disorders due to substance use or the effects of prescribed medications. A review of current medications and informants who knew the individual before they started using the substances or medications in question are critical in making this distinction.

Boundary with attentional symptoms due to other medical conditions

A variety of other medical conditions may influence attentional processes (e.g. hypoglycaemia, hyperthyroidism or hypothyroidism, exposure to toxins, sleep-wake disorders), resulting in temporary or persistent symptoms that resemble or interact with those of attention deficit hyperactivity disorder. As a basis for appropriate management, it is important to evaluate in such cases whether the symptoms are secondary to the medical condition or are more indicative of comorbid attention deficit hyperactivity disorder.

6A06 Stereotyped movement disorder

Essential (required) features

- The persistent (e.g. lasting for several months) presence of voluntary, repetitive, stereotyped, apparently purposeless and often rhythmic movements (e.g. body rocking, hand flapping, head banging, eye poking and hand biting) that are not caused by the direct physiological effects of a substance or medication (including withdrawal) is required for diagnosis.

- Stereotyped movements result in significant interference with the ability to engage in normal daily activities, or result in self-inflicted bodily injury severe enough to be an independent focus of clinical attention or that would result in self-injury if protective measures were not taken.
- Onset occurs during the developmental period, typically at an early age.

Specifiers related to self-injury

A specifier should be applied with the diagnosis of stereotyped movement disorder to indicate whether it involves movements that result in physical harm to the individual.

6A06.0 Stereotyped movement disorder without self-injury

- Stereotyped movements do not result in physical harm to the affected individual even without the presence of protective measures. These behaviours typically include body rocking, head rocking, finger-flicking mannerisms and hand flapping.

6A06.1 Stereotyped movement disorder with self-injury

- Stereotyped movements result in harm to the affected individual that is severe enough to be an independent focus of clinical attention, or would result in self-injury if protective measures (e.g. helmet to prevent head injury) were not taken. These behaviours typically include head banging, face slapping, eye poking and biting of the hands, lips or other body parts.

6A06.Z Stereotyped movement disorder, unspecified

Additional clinical features

- Co-occurrence of stereotyped movement disorder and disorders of intellectual development is common.

Boundary with normality (threshold)

- Many young children show stereotyped behaviours (e.g. thumb sucking). In older children and adults, repetitive behaviours such as leg shaking, finger drumming/tapping or self-stimulatory behaviours (e.g. masturbation) may be seen in response to boredom. These behaviours are differentiated from stereotyped movement disorder because they do not result in significant interference with normal daily activities; nor do they result in self-inflicted bodily injury that is severe enough to be an independent focus of clinical attention.

Course features

- Among typically developing children, stereotyped movements remit over time (or become suppressed). Among individuals with a disorder of intellectual development and autism spectrum disorder with disorder of intellectual development, however, stereotyped (and self-injurious) behaviours may persist, though the presentation of these behaviours may change over time.

Developmental presentations

- Onset of stereotyped movement disorder occurs early in the developmental period, with stereotyped movements often emerging before 3 years of age; up to 80% of children who exhibit complex motor stereotyped movements display them before 2 years of age.
- Stereotyped movements are common in typically developing children, and often resolve with time – particularly simple stereotyped movements (such as rocking). The development of complex stereotyped movements is estimated to occur in 3–4% of children.
- Stereotyped movement disorder commonly co-occurs with disorders of intellectual development and autism spectrum disorder.

Sex- and/or gender-related features

- Preschool-aged boys with autism spectrum disorder and with a disorder of intellectual development tend to have higher rates of co-occurring stereotyped movement disorder.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with autism spectrum disorder

Repetitive and stereotyped motor movements such as whole-body movements (e.g. rocking), gait atypicalities (e.g. walking on tiptoes) and unusual hand or finger movements can be a characteristic feature of autism spectrum disorder, but are differentiated from stereotyped movement disorder by the presence of additional significant limitations in the capacity for reciprocal social interactions and social communication. Assignment of both diagnoses may be warranted if the stereotyped motor movements constitute a separate focus of clinical attention (e.g. due to self-injury).

Boundary with obsessive-compulsive disorder

In contrast to stereotyped movement disorder, repetitive behaviours (i.e. compulsions) observed in obsessive-compulsive disorder are typically more complex, and are aimed at neutralizing unwanted intrusive thoughts (i.e. obsessions) and reducing associated negative emotions (e.g. anxiety).

Boundary with body-focused repetitive behaviour disorders

Body-focused repetitive behaviour disorders (e.g. trichotillomania and excoriation disorder) are characterized by recurrent and habitual behaviours directed at the integument (e.g. hair and skin). In contrast, stereotyped movements in stereotyped movement disorder rarely include hair-pulling or skin-picking behaviour; if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable, utilizing the same muscle groups in a particular sequence to produce the behaviour. In addition, stereotyped movements are more likely to present very early in life (below 2 years of age), whereas body-focused repetitive behaviour disorders typically have an onset in later childhood or early adolescence.

Boundary with Tourette syndrome and other tic disorders

In contrast to tic disorders including Tourette syndrome, stereotyped movements in stereotyped movement disorder tend to be composed of coordinated movements that are patterned and predictable, and can be interrupted with distraction. Stereotyped movement disorder is further differentiated from tics and Tourette syndrome because the symptoms tend to emerge at a younger age, last longer than typical tics, lack a premonitory sensory urge, and may be experienced as enjoyable.

Boundary with drug-induced dystonia (tardive dyskinesia).

Drug-induced dystonia is a movement disorder (classified in Chapter 8 on diseases of the nervous system) that is most frequently caused by antipsychotic medication. It is also sometimes referred to as tardive dyskinesia. Symptoms may include involuntary oral or facial movements or, less commonly, irregular trunk or limb movements. A diagnosis of stereotyped movement disorder is not appropriate in such cases.

Boundary with diseases of the nervous system

Involuntary movements associated with diseases of the nervous system usually follow a typical pattern with the presence of pathognomic signs and symptoms. If stereotyped movements are associated with Lesch-Nyhan syndrome or another specific disease of the nervous system or neurodevelopmental disease, stereotyped movement disorder should not be diagnosed unless the movements become a separate focus of clinical attention. In such cases, both diagnoses may be assigned.

6A0Y Other specified neurodevelopmental disorder

Essential (required) features

- The presentation is characterized by significant difficulties in the acquisition and execution of specific intellectual, motor, language or social functions that arise during the developmental period and share primary clinical features with other neurodevelopmental disorders.
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the neurodevelopmental disorders grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a psychotic disorder, a mood disorder, a disorder specifically associated with stress).
- The symptoms or behaviours are not developmentally typical and are not entirely attributable to external factors, such as economic or environmental disadvantage or lack of access to educational opportunities.
- The symptoms or behaviours are not a manifestation of another medical condition that is not classified under mental and behavioural disorders, and are not due to the effects of a substance (e.g. alcohol) or medication (e.g. bronchodilators) on the central nervous system, including withdrawal effects.
- The difficulties result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6A0Z Neurodevelopmental disorder, unspecified

Secondary-parented categories in neurodevelopmental disorders

8A05.0 Primary tics and tic disorders

The following categories – Tourette syndrome, chronic motor tic disorder and chronic phonic tic disorder – are classified in the grouping of primary tics and tic disorders in Chapter 8 on diseases of the nervous system, but are cross-listed here because of their high co-occurrence and familial association with neurodevelopmental disorders.

8A05.00 Tourette syndrome

Essential (required) features

- The presence of both motor tics and phonic tics that may or may not manifest concurrently or continuously during the symptomatic course is required for diagnosis.
- Motor and phonic tics are defined as sudden, rapid, non-rhythmic and recurrent movements or vocalizations, respectively.
- Motor and phonic tics have been present for at least 1 year with onset during the developmental period.
- The symptoms are not a manifestation of another medical condition (e.g. Huntington disease), and are not due to the effects of a substance or medication on the central nervous system (e.g. amfetamine), including withdrawal effects (e.g. from benzodiazepines).

Additional clinical features

- Tourette syndrome frequently co-occurs with attention deficit hyperactivity disorder, and impulsivity, disinhibition, anxiety and immature behaviour may be associated features of both diagnoses.
- Motor and phonic tics in Tourette syndrome may be voluntarily suppressed for short periods of time, may be exacerbated by stress, and may diminish during sleep or during periods of focused enjoyable activity.
- Tics are often highly suggestible – for example, when an individual with Tourette syndrome is asked about specific symptoms, old tics that have been absent for some time may transiently reappear.

Boundary with normality (threshold)

- Transient motor or phonic tics (e.g. eye blinking, throat clearing) are common during childhood, and are differentiated from Tourette syndrome by their transient nature.

Course features

- The onset of Tourette syndrome commonly occurs during childhood (between the ages of 4 and 6 years), with peak symptom severity occurring between the ages of 8 and 12 years. Across adolescence, there is decreasing likelihood of onset. Onset during adulthood is rare and most often associated with severe psychosocial stressors, use of specific drugs (e.g. cocaine) or an insult to the central nervous system (e.g. post-viral encephalitis).
- The onset of Tourette syndrome is typically characterized by transient bouts of simple motor tics such as eye blinking or head jerks. Phonic tics usually begin 1–2 years after the onset of motor symptoms and initially tend to be simple in character (e.g. throat clearing, grunting, or squeaking), but then may gradually develop into more complex vocal symptoms that include repetition of one's own or another person's speech or obscene utterances (i.e. coprolalia). Sometimes the latter is associated with gestural echopraxia, which also may be of an obscene nature (i.e. copropraxia).
- Vocal and/or motor tics may wax and wane in severity, with some individuals experiencing remission of symptoms for weeks or months at a time. Eventually the symptoms become more persistent, and can be accompanied by detrimental effects to personal, family, social, educational, occupational or other important areas of functioning.
- The majority of individuals with Tourette syndrome will experience significantly diminished symptoms by early adulthood, with more than one third experiencing a full remission of symptoms.
- Evidence suggests a good long-term clinical course for individuals with a solitary diagnosis of Tourette syndrome. Those with co-occurring conditions (e.g. obsessive-compulsive disorder, attention deficit hyperactivity disorder, anxiety and fear-related disorders, depressive disorders) tend to exhibit a poorer prognosis.

Developmental presentations

- The prevalence rate of Tourette syndrome among school-aged children has been estimated at approximately 0.5%.
- Motor and phonic tics in Tourette syndrome tend to be most severe between the ages of 8 and 12 years, gradually diminishing throughout adolescence. By late childhood (approximately 10 years of age), most children become aware of premonitory urges (bodily sensations) and increased discomfort preceding – and relief of tension following – motor and vocal tics.
- The vocal symptom of coprolalia (inappropriate swearing, experienced involuntarily) is uncommon, affecting only 10–15% of individuals with Tourette syndrome, and tends to emerge in mid-adolescence.
- Many adults with childhood-onset Tourette syndrome report attenuated symptoms, though a small number of adults will continue to experience severe tic symptoms.

- The pattern of co-occurring disorders appears to vary with developmental stage. Children with Tourette syndrome are more likely to experience attention deficit hyperactivity disorder, obsessive-compulsive disorder, autism spectrum disorder and separation anxiety disorder compared to adolescents and adults. Adolescents and adults are more likely than children to develop a depressive disorder, a disorder due to substance use or a bipolar disorder.

Culture-related features

- Symptoms of Tourette syndrome are consistent across cultural groups.
- If vocalizations or movements have a specific function or meaning in the context of an individual's culture and are used in ways that are consistent with that cultural function or meaning, they should not be considered evidence of Tourette syndrome.

Sex- and/or gender-related features

- Tourette syndrome is more common among males than females (gender ratio ranging from 2:1 to 4:1).
- Course and symptom presentation do not vary by gender.
- Women with persistent tic disorders may be more likely to experience co-occurring anxiety and fear-related disorders and depressive disorders.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with autism spectrum disorder and stereotyped movement disorder

Repetitive and stereotyped motor movements such as whole-body movements (e.g. rocking) and unusual hand or finger movements can be a characteristic feature of autism spectrum disorder and of stereotyped movement disorder. These behaviours can appear similar to tics, but are differentiated because they tend to be more stereotyped, last longer than the duration of a typical tic, tend to emerge at a younger age, are not characterized by premonitory sensory urges, are often experienced by the individual as soothing or rewarding, and can generally be interrupted with distraction.

Boundary with obsessive-compulsive disorder

Repetitive, recurrent movements or vocalizations can also be symptomatic of obsessive-compulsive disorder. Tics can be differentiated from obsessive-compulsive disorder because they appear unintentional in nature and clearly utilize a discrete muscle group. However, it can be difficult to distinguish between complex tics and compulsions associated with obsessive-compulsive disorder. Although tics (both complex and simple) are preceded by premonitory sensory urges, which may diminish over time, tics are not aimed at neutralizing antecedent cognitions (e.g. obsessions) or reducing physiological arousal (e.g. anxiety). Many individuals exhibit symptoms of both obsessive-compulsive disorder and Tourette syndrome, and both diagnoses may be assigned if the diagnostic requirements for each are met.

Boundary with self-injurious and self-mutilating behaviours

With enough force and repetition, motor tics may lead to self-injury. However, unlike self-injurious and self-mutilating behaviour, Tourette syndrome is not associated with an intention to cause self-injury.

8A05.01 Chronic motor tic disorder

Essential (required) features

- The persistent presence of motor tics is required for diagnosis.
- Motor tics are defined as sudden, rapid, non-rhythmic and recurrent movements.
- Motor tics have been present for at least 1 year, with onset during the developmental period.

Note: other CDDR elements for chronic motor tic disorder are provided below, following the essential features for chronic phonic tic disorder.

8A05.02 Chronic phonic tic disorder

Essential (required) features

- The persistent presence of phonic tics is required for diagnosis.
- Phonic tics are defined as sudden, rapid, non-rhythmic and recurrent vocalizations.
- Phonic tics have been present for at least 1 year, with onset during the developmental period.

Additional clinical features for chronic motor tic disorder and chronic phonic tic disorder

- Motor and phonic tics may be voluntarily suppressed for short periods of time, may be exacerbated by stress, and may diminish during sleep or during periods of focused enjoyable activity.
- Tics are often highly suggestible – for example, when an individual with chronic motor tic disorder or chronic phonic tic disorder is asked about specific symptoms, old tics that have been absent for some time may transiently reappear.

Boundary with normality (threshold) for chronic motor tic disorder and chronic phonic tic disorder

- Transient motor or phonic tics (e.g. eye blinking, throat clearing) are common during childhood, and are differentiated from chronic motor tic disorder and chronic phonic tic disorder by their transient nature.

Developmental presentations for chronic motor tic disorder and chronic phonic tic disorder

- The prevalence of chronic motor tic disorder is estimated at between 0.3% and 0.8% of school-aged children.
- Less is known about the prevalence of chronic phonic tic disorder.

Culture-related features for chronic motor tic disorder and chronic phonic tic disorder

- If vocalizations or movements have a specific function or meaning in the context of an individual's culture and are used in ways that are consistent with that cultural function or meaning, they should not be considered evidence of chronic motor tic disorder or chronic phonic tic disorder.

Sex- and/or gender-related features for chronic motor tic disorder and chronic phonic tic disorder

- Women with persistent tic disorders may be more likely to experience co-occurring anxiety and fear-related disorders and depressive disorders.

Boundaries with other disorders and conditions (differential diagnosis) for chronic motor tic disorder and chronic phonic tic disorder

Boundary with autism spectrum disorder and stereotyped movement disorder

Repetitive and stereotyped motor movements such as whole-body movements (e.g. rocking) and unusual hand or finger movements can be a characteristic feature of autism spectrum disorder and of stereotyped movement disorder. These behaviours can appear similar to tics but are differentiated because they tend to be more stereotyped, last longer than the duration of a typical tic, tend to emerge at a younger age, are not characterized by premonitory sensory urges, are often experienced by the individual as soothing or rewarding, and can generally be interrupted with distraction.

Boundary with obsessive-compulsive disorder

Repetitive, recurrent movements or vocalizations can also be symptomatic of obsessive-compulsive disorder. Tics can be differentiated from obsessive-compulsive disorder because they appear unintentional in nature and clearly utilize a discrete muscle group. However, it can be difficult to distinguish between complex tics and compulsions associated with obsessive-compulsive disorder. Although tics (both complex and simple) are preceded by premonitory sensory urges, which may diminish over time, tics are not aimed at neutralizing antecedent cognitions (e.g. obsessions) or reducing physiological arousal (e.g. anxiety). Many individuals exhibit symptoms of both obsessive-compulsive disorder and chronic motor tic disorder or chronic phonic tic disorder, and both diagnoses may be assigned if the diagnostic requirements for each are met.

Boundary with self-injurious and self-mutilating behaviours

With enough force and repetition, motor tics may lead to self-injury. However, unlike self-injurious and self-mutilating behaviour, chronic motor tic disorder is not associated with an intention to cause self-injury.

Schizophrenia and other primary psychotic disorders

Schizophrenia and other primary psychotic disorders is a grouping of disorders characterized by significant impairments in reality testing, and alterations in behaviour as manifested in symptoms such as delusions, hallucinations, formal thought disorder (typically manifested as disorganized speech) and disorganized behaviour. They may be accompanied by psychomotor disturbances and negative symptoms such as blunted or flat affect. These symptoms do not occur primarily as a result of substance use (e.g. hallucinogen intoxication) or another medical condition not classified under mental, behavioural and neurodevelopmental disorders (e.g. Huntington disease). The disorders in this grouping are referred to as "primary psychotic disorders" because psychotic symptoms are their defining feature. Psychotic symptoms may also occur in the context of other mental disorders (e.g. in mood disorders or dementia), but in these cases the symptoms occur alongside other characteristic features of those disorders. Whereas experiences of reality loss/distortion occur on a continuum and can be found throughout the population, disorders in this group represent patterns of symptoms and behaviours that occur with sufficient frequency and intensity to deviate from expected cultural or subcultural expectations.

Schizophrenia and other primary psychotic disorders include the following:

6A20	Schizophrenia
6A21	Schizoaffective disorder
6A22	Schizotypal disorder
6A23	Acute and transient psychotic disorder
6A24	Delusional disorder
6A2Y	Other specified primary psychotic disorder
6A2Z	Schizophrenia or other primary psychotic disorder, unspecified.

In the context of schizotypal disorder, symptoms may be substantially attenuated such that they may be characterized as eccentric or peculiar rather than overtly psychotic.

The categories in the grouping of schizophrenia and other primary psychotic disorders should not be used to classify the expression of ideas, beliefs or behaviours that are culturally sanctioned. Many religious or cultural practices worldwide incorporate experiences qualitatively similar in nature to the symptoms described for this grouping of disorders, and these should not be considered to be pathological.

General cultural considerations for schizophrenia and other primary psychotic disorders

- Beliefs vary across cultures such that those considered odd or unusual in one culture may be normative in another. For example, belief in witchcraft or supernatural forces, or fears that transgressing cultural norms can lead to misfortune, are typical in many cultures. Distress may be expressed in ways that may be misinterpreted as evidence of psychotic symptoms, such as pseudo-hallucinations and overvalued ideas or dissociative experiences related to trauma.
- In some cultures, distress due to social circumstances may be expressed in ways that can be misinterpreted as psychotic symptoms (e.g. overvalued ideas and pseudo-hallucinations) but that instead are considered normal for the person's subgroup.
- Symptom presentation of schizophrenia and other primary psychotic disorders may vary across cultures. For example, the content and form of hallucinations (e.g. visual hallucinations are more common in some cultural groups and in some countries) or delusions may be culturally derived, making it difficult to differentiate among culturally normal experiences, overvalued ideas, ideas of reference and transient psychosis. For instance, in several cultures (e.g. southern China, Latin America) it is common to expect the spirit of a deceased relative to visit the homes of living relatives soon after they die. Hearing, seeing or interacting with this spirit may be reported without notable pathological sequelae. Clarifying the cultural meaning of these experiences can aid in understanding the diagnostic significance of the symptom presentation.
- Cultural mismatch between the individual and the clinician may complicate the evaluation of schizophrenia and other primary psychotic disorders. Collateral information from family, community, religious or cultural reference groups may help clarify the diagnosis.
- Ethnic minority and migrant groups are more likely than those in the general population to receive a diagnosis of schizophrenia and other primary psychotic disorder. This may be due to misdiagnosis or to greater risk of psychosis resulting from migration traumas, social isolation, minority and acculturative stress, discrimination and victimization.
- Caution is advised when assessing psychotic symptoms through interpreters or in a second or third language because of the risk of misconstruing unfamiliar metaphors as delusions, and natural defensiveness as paranoia or emotional blunting.

6A20 Schizophrenia

Essential (required) features

- At least two of the following symptoms must be present (by the individual's report or through observation by the clinician or other informants) most of the time for a period of 1 month or more. At least one of the qualifying symptoms should be from items a) to d) below:
  a) persistent delusions (e.g. grandiose delusions, delusions of reference, persecutory delusions);
  b) persistent hallucinations (most commonly auditory, although they may be in any sensory modality);

c) disorganized thinking (formal thought disorder) (e.g. tangentiality and loose associations, irrelevant speech, neologisms) – when severe, the person's speech may be so incoherent as to be incomprehensible ("word salad");
d) experiences of influence, passivity or control (i.e. the experience that one's feelings, impulses, actions or thoughts are not generated by oneself, are being placed in one's mind or withdrawn from one's mind by others, or that one's thoughts are being broadcast to others);
e) negative symptoms such as affective flattening, alogia or paucity of speech, avolition, asociality and anhedonia;
f) grossly disorganized behaviour that impedes goal-directed activity (e.g. behaviour that appears bizarre or purposeless, unpredictable or inappropriate emotional responses that interferes with the ability to organize behaviour);
g) psychomotor disturbances such as catatonic restlessness or agitation, posturing, waxy flexibility, negativism, mutism or stupor. ***Note:*** if the full syndrome of catatonia (p. 202) is present in the context of schizophrenia, the diagnosis of 6A40 Catatonia associated with another mental disorder should also be assigned.

- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication (e.g. corticosteroids) on the central nervous system, including withdrawal effects (e.g. from alcohol).

Course specifiers for schizophrenia

The following specifiers should be applied to identify the course of schizophrenia, including whether the individual currently meets the diagnostic requirements of schizophrenia or is in partial or full remission. Course specifiers are also used to indicate whether the current episode is the first episode of schizophrenia, whether there have been multiple such episodes, or whether symptoms have been continuous over an extended period of time.

6A20.0 Schizophrenia, first episode

- The *first episode* specifier should be applied when the current or most recent episode is the first manifestation of schizophrenia meeting all diagnostic requirements in terms of symptoms and duration. If there has been a previous episode of schizophrenia or schizoaffective disorder, the *multiple episodes* specifier should be applied.

6A20.00 Schizophrenia, first episode, currently symptomatic

- All diagnostic requirements for schizophrenia in terms of symptoms and duration are currently met, or have been met within the past month.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

Note: if the duration of the episode is more than 1 year, the *continuous* specifier may be used instead, depending on the clinical situation.

6A20.01 Schizophrenia, first episode, in partial remission

- The full diagnostic requirements for schizophrenia have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizophrenia following an asymptomatic period in a person who has previously met the diagnostic requirements for schizophrenia.

6A20.02 Schizophrenia, first episode, in full remission

- The full diagnostic requirements for schizophrenia have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

6A20.0Z Schizophrenia, first episode, unspecified

6A20.1 Schizophrenia, multiple episodes

- The *multiple episodes* specifier should be applied when there have been a minimum of two episodes meeting all diagnostic requirements of schizophrenia or schizoaffective disorder in terms of symptoms, with a period of partial or full remission between episodes lasting at least 3 months, and the current or most recent episode is schizophrenia. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes. During the period of remission, the diagnostic requirements of schizophrenia are either only partially fulfilled or absent.

6A20.10 Schizophrenia, multiple episodes, currently symptomatic

- All symptom requirements for schizophrenia are currently met, or have been met within the past month. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes.
- There have been a minimum of two episodes of schizophrenia or a previous episode of schizoaffective disorder, with a period of partial or full remission between episodes lasting at least 3 months.

6A20.11 Schizophrenia, multiple episodes, in partial remission

- The full diagnostic requirements for schizophrenia have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.

- There have been a minimum of two episodes of schizophrenia or a previous episode of schizoaffective disorder, with a period of partial or full remission between episodes lasting at least 3 months.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizophrenia following an asymptomatic period.

6A20.12 Schizophrenia, multiple episodes, in full remission

- The full diagnostic requirements for schizophrenia have not been met within the past month, and no clinically significant symptoms remain.
- There have been a minimum of two episodes of schizophrenia or a previous episode of schizoaffective disorder, with a period of partial or full remission between episodes lasting at least 3 months.

6A20.1Z Schizophrenia, multiple episodes, unspecified

6A20.2 Schizophrenia, continuous

- The *continuous* specifier should be applied when symptoms fulfilling all diagnostic requirements of schizophrenia have been present for almost all of the course of the disorder during the person's lifetime since its first onset, with periods of subthreshold symptoms being very brief relative to the overall course. In order to apply this specifier to a first episode, the duration of schizophrenia should be at least 1 year. In that case, the *continuous* specifier should be applied instead of the *first episode* specifier.

6A20.20 Schizophrenia, continuous, currently symptomatic

- All symptom requirements for schizophrenia are currently met, or have been met within the past month.
- Symptoms meeting the diagnostic requirements for schizophrenia have been present for almost all of the course of the disorder during the person's lifetime since its first onset.
- Periods of partial or full remission have been very brief relative to the overall course, and none have lasted for 3 months or longer.
- To apply the *continuous* specifier to a first episode, symptoms meeting the diagnostic requirements for schizophrenia must have been present for at least 1 year.

6A20.21 Schizophrenia, continuous, in partial remission

- The full diagnostic requirements for schizophrenia, continuous were previously met but have not been met within the past month.
- Some clinically significant symptoms of schizophrenia remain, which may or may not be associated with functional impairment.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizophrenia following an asymptomatic period.

6A20.22 Schizophrenia, continuous, in full remission

- The full diagnostic requirements for schizophrenia, continuous were previously met but have not been met within the past month.
- No clinically significant symptoms of schizophrenia remain.

6A20.2Z Schizophrenia, continuous, unspecified

6A20.Y Other specified episode of schizophrenia

6A20.Z Schizophrenia, episode unspecified

Additional clinical features

- The onset of schizophrenia may be acute, with serious disturbance apparent within a few days, or insidious, with a gradual development of signs and symptoms.
- A prodromal phase often precedes the onset of psychotic symptoms by weeks or months. The characteristic features of this phase often include loss of interest in work or social activities, neglect of personal appearance or hygiene, inversion of the sleep cycle and attenuated psychotic symptoms, accompanied by negative symptoms, anxiety/agitation or varying degrees of depressive symptoms.
- Between acute episodes there may be residual phases, which are similar phenomenologically to the prodromal phase.
- Schizophrenia is frequently associated with significant distress and significant impairment in personal, family, social, educational, occupational or other important areas of functioning. However, distress and psychosocial impairment are not requirements for a diagnosis of schizophrenia.

Boundary with normality (threshold)

- Psychotic-like symptoms or unusual subjective experiences may occur in the general population, but these are usually fleeting in nature and are not accompanied by other

symptoms of schizophrenia or a deterioration in psychosocial functioning. In schizophrenia, multiple persistent symptoms are present, and are typically accompanied by impairment in cognitive functioning and other psychosocial problems.

Course features

- The course and onset of schizophrenia is variable. Some experience exacerbations and remission of symptoms periodically throughout their lives, others experience a gradual worsening of symptoms, and a smaller proportion experience complete remission of symptoms.
- Positive symptoms tend to diminish naturally over time, whereas negative symptoms often persist and are closely tied to a poorer prognosis. Cognitive symptoms also tend to be more persistent, and when present are associated with ongoing functional impairment.
- Early-onset schizophrenia is typically associated with a poorer prognosis whereas affective and social functioning are more likely to be preserved with later onset.

Developmental presentations

- Onset of fully symptomatic schizophrenia before puberty is extremely rare; when it occurs it is often preceded by a decline in social and academic functioning, odd behaviour, and a change in affect observable during the prodromal phase. Childhood onset is also associated with a greater prevalence of delays in social, language or motor development and co-occurring disorder of intellectual development or developmental learning disorder.
- In children and young adolescents, auditory hallucinations most commonly occur as a single voice commenting on or commanding behaviour whereas in adults such hallucinations are more typically experienced as multiple conversing voices.
- In children and adolescents, it may be challenging to differentiate delusions and hallucinations from more developmentally typical phenomena (e.g. a "monster" under the child's bed, an imaginary friend), actual plausible life experiences (e.g. being teased or bullied at school), and irrational or magical thinking common in childhood (e.g. that thinking about something will make it happen).
- Among children with schizophrenia, negative symptoms, hallucinations and disorganized thinking – including loose associations, illogical thinking and paucity of speech – tend to be prominent features of the clinical presentation. Disorganized thinking and behaviour occur in a variety of disorders that are common in childhood (e.g. autism spectrum disorder, attention deficit hyperactivity disorder), which should be considered before attributing the symptoms to the much less common childhood schizophrenia.

Culture-related features

- Cultural factors may influence the onset, symptom pattern, course and outcome of schizophrenia. For example, among migrants and ethnic and cultural minority communities, living in areas with a low proportion of their own migrant, ethnic or cultural group (low "ethnic density") is associated with higher rates of schizophrenia. In addition, etiological or course-related factors may be affected by culture at the level of the family (e.g. level of family support or style of family interaction, such as expressed emotion) or at the societal context (e.g. industrialization, urbanization). For example, the prevalence of schizophrenia is much higher in urban than rural settings.
- The risk of misdiagnosing the expression of distress as indicative of schizophrenia or another primary psychotic disorder may be increased among ethnic minority and immigrant groups, and in other situations in which the clinician is unfamiliar with culturally normative expressions of distress. These include situations involving spiritual or supernatural beliefs or resulting from migration trauma, social isolation, minority and acculturative stress, discrimination and victimization.

Sex- and/or gender-related features

- Schizophrenia is more prevalent among males.
- The age of onset of the first psychotic episode differs by gender, with a greater proportion of males experiencing onset in their early to mid-20s and females in their late 20s.
- Females with schizophrenia tend to report more positive symptoms that increase in severity over the course of their lives. Females also tend to have greater mood disturbance and a greater prevalence of subsequent or co-occurring mental disorders (e.g. schizoaffective disorder, depressive disorders).
- Females with schizophrenia are less likely to exhibit disorganized thinking, negative symptoms and social impairment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizoaffective disorder

The diagnoses of schizophrenia and schizoaffective disorder are intended to apply to the current or most recent episode of the disorder. In other words, a previous diagnosis of schizoaffective disorder does not preclude a diagnosis of schizophrenia, and vice versa. In both schizophrenia and schizoaffective disorder, at least two the characteristic symptoms of schizophrenia are present most of the time for a period of 1 month or more. In schizoaffective disorder, the symptoms of schizophrenia are present concurrently with mood symptoms that meet the full diagnostic requirements of a mood episode and last for at least 1 month, and the onsets of the psychotic and mood symptoms are either simultaneous or occur within a few days of one another. In schizophrenia, co-occurring mood symptoms, if any, either do not persist for as long as 1 month or are not of sufficient severity

to meet the requirements of a moderate or severe depressive episode, a manic episode or a mixed episode. (See mood episode descriptions, p. 212.) An episode that initially meets the diagnostic requirements for schizoaffective disorder in which only the mood symptoms remit, so that the duration of psychotic symptoms without mood symptoms is much longer than the duration of concurrent symptoms, may be best characterized as an episode of schizophrenia.

Boundary with acute and transient psychotic disorder

The psychotic symptoms in schizophrenia persist for at least 1 month in their full, florid form. In contrast, the symptoms in acute and transient psychotic disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Such rapid shifts would be unusual in schizophrenia. Negative symptoms are often present in schizophrenia, but do not occur in acute and transient psychotic disorder. The duration of acute and transient psychotic disorder does not exceed 3 months, and most often lasts from a few days to 1 month, compared to a much longer typical course for schizophrenia. In cases that meet the diagnostic requirements for schizophrenia except that they have lasted less than the duration required for a diagnosis (i.e. 1 month) in the absence of a previous history of schizophrenia, a diagnosis of other specified primary psychotic disorder and not acute and transient psychotic disorder should be assigned.

Boundary with schizotypal disorder

Schizotypal disorder is characterized by an enduring pattern of unusual speech, perceptions, beliefs and behaviours that resemble attenuated forms of the defining symptoms of schizophrenia. Schizophrenia is differentiated from schizotypal disorder based entirely on the intensity of the symptoms: schizophrenia is diagnosed if the symptoms are sufficiently intense to meet diagnostic requirements.

Boundary with delusional disorder

Both schizophrenia and delusional disorder may be characterized by persistent delusions. If other features are present that meet the diagnostic requirements of schizophrenia (i.e. persistent hallucinations; disorganized thinking; experiences of influence, passivity or control; negative symptoms; disorganized or abnormal psychomotor behaviour), a diagnosis of schizophrenia should be made instead of a diagnosis of delusional disorder. However, hallucinations that are consistent with the content of the delusions and do not occur persistently (i.e. with regular frequency for 1 month or longer) are consistent with a diagnosis of delusional disorder rather than schizophrenia. Delusional disorder is generally characterized by relatively preserved personality and less deterioration and impairment in social and occupational functioning than schizophrenia, and individuals with delusional disorder tend to come to clinical attention for the first time at a later age. Individuals with symptom presentations consistent with delusional disorder (e.g. delusions and related, circumscribed hallucinations) but who have not met the minimum duration requirement of 3 months should not be assigned a diagnosis of schizophrenia, even though the combination of persistent delusions and related hallucinations technically meets diagnostic requirements for schizophrenia. Instead, a diagnosis of other specified primary psychotic disorder is more appropriate in such cases.

Boundary with moderate or severe depressive episodes in single episode depressive disorder, recurrent depressive disorder, and bipolar type I and bipolar type II disorders

Psychotic symptoms may also occur during moderate or severe depressive episodes. Delusions during depressive episodes may resemble delusions observed in schizophrenia, and are commonly persecutory or self-referential (e.g. being pursued by authorities because of imaginary crimes). Delusions of guilt (e.g. falsely blaming oneself for wrongdoing), poverty (e.g. being bankrupt) or impending disaster (perceived to have been brought on by the individual), as well as somatic delusions (e.g. of having contracted some serious disease) and nihilistic delusions (e.g. believing body organs do not exist), are also known to occur. Experiences of passivity, influence or control (e.g. thought insertion, thought withdrawal or thought broadcasting) may also occur in moderate or severe depressive episodes. Hallucinations are usually transient, and rarely occur in the absence of

delusions. Auditory hallucinations (e.g. derogatory or accusatory voices that berate the individual for imaginary weaknesses or sins) are more common than visual (e.g. visions of death or destruction) or olfactory (e.g. the smell of rotting flesh) hallucinations. However, in a moderate or severe depressive episode with psychotic symptoms, the psychotic symptoms are confined to the mood episode. Schizophrenia is differentiated from depressive episodes in mood disorders by the occurrence of psychotic and other symptoms that meet the diagnostic requirements of schizophrenia during periods without mood symptoms that meet the diagnostic requirements of a moderate or severe depressive episode. If the diagnostic requirements for both schizophrenia and a moderate or severe depressive episode are met concurrently, and both the psychotic and mood symptoms last for at least 1 month, schizoaffective disorder is the appropriate diagnosis.

Boundary with manic or mixed episodes in bipolar type I disorder

Psychotic symptoms may occur during manic or mixed episodes in bipolar type I disorder. Though all types of psychotic symptoms are known to occur in manic or mixed episodes, grandiose delusions (e.g. being chosen by God, having special powers or abilities) and persecutory and self-referential delusions (e.g. being conspired against because of one's special identity or abilities) are among the most common. Experiences of influence, passivity or control (e.g. thought insertion, thought withdrawal or thought broadcasting) may also occur during manic or mixed episodes. Hallucinations are less frequent and commonly accompany delusions of persecution or reference. They are usually auditory (e.g. adulatory voices), and less commonly visual (e.g. visions of deities), somatic or tactile. However, in a manic or mixed episode with psychotic symptoms, the psychotic symptoms are confined to the mood episode. Schizophrenia is differentiated from manic or mixed episodes in bipolar type I disorder by the occurrence of psychotic and other symptoms that meet the diagnostic requirements of schizophrenia during periods without mood symptoms that meet the diagnostic requirements of a manic or mixed episode. If the diagnostic requirements for both schizophrenia and bipolar type I disorder are met concurrently, and both psychotic and mood symptoms last for at least 1 month, schizoaffective disorder is the appropriate diagnosis.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

In post-traumatic stress disorder and complex post-traumatic stress disorder, severe flashbacks that involve a complete loss of awareness of present surroundings may occur, intrusive images or memories may have a hallucinatory quality, and hypervigilance may reach proportions that appear to be paranoid. However, the diagnoses of post-traumatic stress disorder and complex post-traumatic stress disorder require a history of exposure to an event or series of events (either short- or long-lasting) of an extremely threatening or horrific nature. These diagnoses also require re-experiencing of the traumatic event in the present, in which the event is not just remembered but rather experienced as occurring again in the here and now, and may include loss of awareness and hallucination-like experiences within this specific context. Re-experiencing of traumatic events is not a characteristic feature of schizophrenia. However, post-traumatic stress disorder and schizophrenia frequently co-occur, and both diagnoses should be assigned when the diagnostic requirements for each are met.

6A21 Schizoaffective disorder

Essential (required) features

- All diagnostic requirements for schizophrenia are met concurrently with mood symptoms that meet the diagnostic requirements of a moderate or severe depressive episode, a manic episode or a mixed episode.

Note: in making a diagnosis of schizoaffective disorder, depressive episodes must include depressed mood, not just diminished interest or pleasure.

- The onsets of the psychotic and mood symptoms are either simultaneous or occur within a few days of one another.
- The duration of symptomatic episodes is at least 1 month for both psychotic and mood symptoms.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. corticosteroids), including withdrawal effects (e.g. from alcohol).

Course specifiers for schizoaffective disorder

The following specifiers should be applied to identify the course of schizoaffective disorder, including whether the individual currently meets the diagnostic requirements of schizoaffective disorder or is in partial or full remission. Course specifiers are also used to indicate whether the current episode is the first episode of schizoaffective disorder, whether there have been multiple such episodes, or whether symptoms have been continuous over an extended period of time.

6A21.0 Schizoaffective disorder, first episode

- The *first episode* specifier should be applied when the current or most recent episode is the first manifestation of the schizoaffective disorder meeting all diagnostic requirements in terms of symptoms and duration. If there has been a previous episode of schizoaffective disorder or schizophrenia, the *multiple episodes* specifier should be applied.

6A21.00 Schizoaffective disorder, first episode, currently symptomatic

- All diagnostic requirements for schizoaffective disorder in terms of symptoms and duration are currently met, or have been met within the past month.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

Note: if the duration of the episode is more than 1 year, the continuous specifier may be used instead, depending on the clinical situation.

6A21.01 Schizoaffective disorder, first episode, in partial remission

- The full diagnostic requirements for schizoaffective disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizoaffective disorder following an asymptomatic period in a person who has previously met the diagnostic requirements for schizoaffective disorder.

6A21.02 Schizoaffective disorder, first episode, in full remission

- The full diagnostic requirements for schizoaffective disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of schizophrenia or schizoaffective disorder.

6A21.0Z Schizoaffective disorder, first episode, unspecified

6A21.1 Schizoaffective disorder, multiple episodes

- The *multiple episodes* specifier should be applied when there have been a minimum of two episodes meeting all diagnostic requirements of schizoaffective disorder or schizophrenia in terms of symptoms, with a period of partial or full remission between episodes lasting at least 3 months, and the current or most recent episode is schizoaffective disorder. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes. During the period of remission, the diagnostic requirements of schizoaffective disorder are either only partially fulfilled or absent.

6A21.10 Schizoaffective disorder, multiple episodes, currently symptomatic

- All symptom requirements for schizoaffective disorder are currently met, or have been met within the past month. Note that the 1-month duration requirement for the first episode does not necessarily need to be met for subsequent episodes.
- There have been a minimum of two episodes of schizoaffective disorder or a previous episode of schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

6A21.11 Schizoaffective disorder, multiple episodes, in partial remission

- The full diagnostic requirements for schizoaffective disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been a minimum of two episodes of schizoaffective disorder or a previous episode of schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizoaffective disorder following an asymptomatic period.

6A21.12 Schizoaffective disorder, multiple episodes, in full remission

- The full diagnostic requirements for schizoaffective disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been a minimum of two episodes of schizoaffective disorder or a previous episode of schizophrenia, with a period of partial or full remission between episodes lasting at least 3 months.

6A21.1Z Schizoaffective disorder, multiple episodes, unspecified

6A21.2 Schizoaffective disorder, continuous

- The *continuous* specifier should be applied when symptoms fulfilling all diagnostic requirements of schizoaffective disorder have been present for almost all of the course of the disorder during the person's lifetime since its first onset, with periods of subthreshold symptoms being very brief relative to the overall course. In order to apply this specifier to a first episode, the duration of schizoaffective disorder should be at least 1 year. In that case, the *continuous* specifier should be applied instead of the *first episode* specifier.

6A21.20 Schizoaffective disorder, continuous, currently symptomatic

- All symptom requirements for schizoaffective disorder are currently met, or have been met within the past month.
- Symptoms meeting the diagnostic requirements for schizoaffective disorder or schizophrenia have been present for almost all of the course of the disorder during the person's lifetime since its first onset.
- Periods of partial or full remission have been very brief relative to the overall course, and none have lasted for three months or longer.
- To apply the *continuous* specifier to a first episode, symptoms meeting the diagnostic requirements for schizoaffective disorder must have been present for at least 1 year.

6A21.21 Schizoaffective disorder, continuous, in partial remission

- The full diagnostic requirements for schizoaffective disorder, continuous were previously met but have not been met within the past month.
- Some clinically significant symptoms of schizoaffective disorder remain, which may or may not be associated with functional impairment.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of schizoaffective disorder following an asymptomatic period.

6A21.22	Schizoaffective disorder, continuous, in full remission

- The full diagnostic requirements for schizoaffective disorder, continuous were previously met but have not been met within the past month.
- No clinically significant symptoms of schizoaffective disorder remain.

6A21.2Z	Schizoaffective disorder, continuous, unspecified

6A21.Y	Other specified schizoaffective disorder

6A21.Z	Schizoaffective disorder, unspecified

Additional clinical features

- The onset of schizoaffective disorder may be acute, with serious disturbance apparent within a few days, or insidious, with a gradual development of signs and symptoms.
- There is often a history of prior mood episodes and a previous diagnosis of a depressive disorder or a bipolar disorder in individuals with schizoaffective disorder.
- A prodromal phase often precedes the onset of psychotic symptoms by weeks or months. The characteristic features of this phase often include loss of interest in work or social activities, neglect of personal appearance or hygiene, inversion of the sleep cycle and attenuated psychotic symptoms, accompanied by negative symptoms, anxiety/agitation or varying degrees of depressive symptoms.
- An episodic course with periods of remission is the most common pattern of progression of the disorder.
- Schizoaffective disorder is frequently associated with significant distress and significant impairment in personal, family, social, educational, occupational or other important areas of functioning. However, distress and psychosocial impairment are not requirements for a diagnosis of schizoaffective disorder.

Boundary with normality (threshold)

- Psychotic-like symptoms or unusual subjective experiences may occur in the general population, but these are usually fleeting in nature and are not accompanied by other symptoms of schizophrenia or a deterioration in psychosocial functioning. In schizoaffective

disorder, multiple persistent symptoms are present, and are typically accompanied by impairment in cognitive functioning and other psychosocial problems.

Course features

- Some people with schizoaffective disorder experience exacerbations and remission of symptoms periodically throughout the illness course, whereas others experience a full remission of symptoms between episodes.

Developmental presentations

- Diagnosis of schizoaffective disorder among children is challenging because the sequence of mood and psychotic symptoms may be difficult for children to describe accurately.
- Children who are diagnosed with schizoaffective disorder are the most severely impaired and have the poorest outcomes among all children diagnosed with psychotic disorders.
- Schizoaffective disorder with manic episodes is more common among young adults whereas schizoaffective disorder with depressive episodes is more common among older adults.

Culture-related features

- See the culture-related features section for schizophrenia, all of which also applies to schizoaffective disorder.
- In addition. culture may affect the expression of mood symptoms, the use of idioms of distress and illness-related metaphors, and the prominence of certain patterns of mood-related symptoms. For example, religious or spiritual views about suicidal ideation or behaviour may decrease reporting and increase associated guilt; and shame may be more prominent than guilt in sociocentric societies. Norms for experiencing and articulating mood symptoms psychologically vary by culture, as does the attribution of distress to interpersonal, social, psychological, biological, supernatural or spiritual concerns.
- Bodily complaints as somatic expressions of depression may predominate over cognitive mood symptoms due to their greater cultural acceptability as indications of the need for clinical attention.

Sex- and/or gender-related features

- Schizoaffective disorder is more prevalent among females – especially schizoaffective disorder with depressive episodes.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia

The diagnoses of schizophrenia and schizoaffective disorder are intended to apply to the current or most recent episode of the disorder. In other words, a previous diagnosis of schizoaffective disorder does not preclude a diagnosis of schizophrenia, and vice versa. In both schizophrenia and schizoaffective disorder, at least two the characteristic symptoms of schizophrenia are present most of the time for a period of 1 month or more. In schizoaffective disorder, the symptoms of schizophrenia are present concurrently with mood symptoms that meet the full diagnostic requirements of a mood episode and last for at least 1 month, and the onsets of the psychotic and mood symptoms are either simultaneous or occur within a few days of one another. In schizophrenia, co-occurring mood symptoms, if any, either do not persist for as long as 1 month or are not of sufficient severity to meet the requirements of a moderate or severe depressive episode, a manic episode or a mixed episode. (See mood episode descriptions, p. 212.) An episode that initially meets the diagnostic requirements for schizoaffective disorder in which only the mood symptoms remit, so that the duration of psychotic symptoms without mood symptoms is much longer than the duration of concurrent symptoms, may be best characterized as an episode of schizophrenia.

Boundary with mood episodes with psychotic symptoms

Schizoaffective disorder, schizophrenia, moderate or severe depressive episodes, manic episodes and mixed episodes are all intended to describe the current episode of the disorder. In schizoaffective disorder, the duration and symptom requirements for schizophrenia are fully met during the mood episode. In a depressive disorder with psychotic symptoms or a bipolar type I disorder with psychotic symptoms, psychotic symptoms occur simultaneously with the mood episodes but do not meet the diagnostic requirements for schizophrenia (e.g. hallucinations without any other psychotic symptoms). It is possible for an individual to meet the diagnostic requirements for each during different periods.

Boundary with acute and transient psychotic disorder

In schizoaffective disorder, the psychotic symptoms persist for at least 1 month in their full, florid form. In contrast, in acute and transient psychotic disorder, the symptom requirements for schizophrenia or a depressive, manic or mixed episode are not met. Moreover, the symptoms in acute and transient psychotic disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Negative symptoms may be present in schizoaffective disorder, but do not occur in acute transient psychotic disorder. The duration of acute and transient psychotic disorder does not exceed 3 months, and most often lasts from a few days to 1 month, compared to a much longer typical course for schizoaffective disorder.

6A22 Schizotypal disorder

Essential (required) features

- An enduring pattern of unusual speech, perceptions, beliefs and behaviours that are not of sufficient intensity or duration to meet the diagnostic requirements of schizophrenia, schizoaffective disorder or delusional disorder is required for diagnosis. The pattern includes several of the following symptoms:
  - constricted affect, such that the individual appears cold and aloof;
  - behaviour or appearance that is odd, eccentric, unusual or peculiar, and is inconsistent with cultural or subcultural norms;
  - poor rapport with others and a tendency towards social withdrawal;
  - unusual beliefs or magical thinking influencing the person's behaviour in ways that are inconsistent with subcultural norms, but not reaching the diagnostic requirements for a delusion;
  - unusual perceptual distortions such as intense illusions, depersonalization, derealization, or auditory or other hallucinations;
  - suspiciousness or paranoid ideas;
  - vague, circumstantial, metaphorical, overelaborate or stereotyped thinking, manifested in odd speech without gross incoherence;
  - obsessive ruminations without a sense that the obsession is foreign or unwanted, often with body dysmorphic, sexual or aggressive content.
- The individual has never met the diagnostic requirements for schizophrenia, schizoaffective disorder or delusional disorder. That is, transient delusions, hallucinations, formal thought disorder, or experiences of influence, passivity or control may occur, but do not last for more than 1 month.
- Symptoms should have been present, continuously or episodically, for at least 2 years.
- The symptoms cause distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g. corticosteroids) – including withdrawal effects (e.g. from alcohol) – and are not better accounted for by another mental, behavioural or neurodevelopmental disorder.

Additional clinical features

- Schizotypal disorder is more prevalent among biological relatives of people with a diagnosis of schizophrenia, and is considered to be a part of the spectrum of schizophrenia-related psychopathology. Having a first-degree relative with schizophrenia gives additional weight to a diagnosis of schizotypal disorder but is not a requirement if the individual is experiencing distress or impairment in psychosocial functioning related to their symptoms.

Boundary with normality (threshold)

- The threshold between symptoms of schizotypal disorder and extravagant, eccentric or unusual behaviour and beliefs in individuals without a diagnosable disorder is sometimes difficult to determine, especially as some people in the general population show eccentric behaviour and report psychotic-like or unusual subjective experiences without any apparent impairment in functioning. Schizotypal disorder should only be diagnosed if the individual is experiencing distress or impairment in personal, family, social, educational, occupational or other important areas of functioning related to their symptoms.

Course features

- The course of schizotypal disorder is relatively stable and chronic, with some fluctuation in symptom intensity. Individuals often have severe functional impairments in academic, occupational and interpersonal domains.
- The following symptoms of schizotypal disorder are typically present prior to full symptomatic onset:
  - poor rapport with others and a tendency towards social withdrawal, suspiciousness or paranoid ideas;
  - vague, circumstantial, metaphorical, overelaborate or stereotyped thinking, manifested in odd speech without gross incoherence.
- The disorder may persist over years with fluctuations of intensity and symptom expression, but rarely evolves into schizophrenia.
- Affected individuals typically seek treatment for co-occurring depressive or anxiety and fear-related disorders. Although intervention has demonstrated some efficacy in improving mood and anxiety symptoms, suspicion and paranoia often persist.

Developmental presentations

- Schizotypal disorder typically begins in late adolescence or early adulthood, without a definite age of onset.
- Some symptoms of schizotypal disorder may first appear in childhood and adolescence, affecting peer relationships and academic performance.

Culture-related features

- A person's behaviour, appearance, speech or illness explanations may appear odd or unusual to clinicians who are unfamiliar with the person's culture, but in the context of the person's cultural group may be either normative or not sufficiently severe to reach the threshold of a mental disorder. Concepts and experiences that are common in some cultures include witchcraft or sorcery, speaking in tongues, life beyond death, shamanism, mind reading, sixth sense, evil eye, spirit possession and magical beliefs related to health and illness.
- Reduced engagement in interpersonal relationships may be part of some cultural or religious practices (e.g. monastic isolation) and should not be considered pathological.

Sex- and/or gender-related features

- Schizotypal disorder is slightly more prevalent among males.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia

In the prodromal and residual phases of schizophrenia, the individual may experience extended periods of perceptual distortions, unusual beliefs, odd or digressive speech, social withdrawal and other symptoms that are characteristic of schizotypal disorder. A diagnosis of schizophrenia, however, requires a period of at least 1 month of psychotic symptoms, in contrast to schizotypal disorder, which requires that any psychotic-like symptoms do not meet the diagnostic requirements for schizophrenia in terms of severity or duration. Moreover, the pattern of unusual speech, perceptions, beliefs and behaviours tends to be stable over time – even over years – in individuals with schizotypal disorder, in contrast to an evolving symptom picture either in prodromal or residual phases of schizophrenia.

Boundary with autism spectrum disorder

Interpersonal difficulties seen in schizotypal disorder may share some features of autism spectrum disorder, including poor rapport with others and social withdrawal. However, individuals with schizotypal disorder do not exhibit restricted, repetitive and stereotyped patterns of behaviour, interests or activities.

Boundary with personality disorder

Personality disorder is defined as an enduring disturbance in the individual's way of interpreting and experiencing themselves, others and the world that result in maladaptive patterns of emotional expression and behaviour, and produce significant problems in functioning that are particularly evident in interpersonal relationships. Individuals with schizotypal disorder should not be given an additional diagnosis of personality disorder based on disturbances in functioning and interpersonal

relationships that are entirely a consequence of the symptoms of schizotypal disorder. However, if additional personality features are present that are judged to produce significant problems in interpersonal functioning, an additional diagnosis of personality disorder may be appropriate.

6A23 Acute and transient psychotic disorder

Essential (required) features

- Acute onset of psychotic symptoms – which can include delusions, hallucinations, disorganized thinking or experiences of influence, passivity or control – that emerge without a prodrome, progressing from a non-psychotic state to a clearly psychotic state within 2 weeks, is required for diagnosis. Psychomotor disturbances may also be present, including catatonia.
- Symptoms change rapidly, both in nature and intensity. Such changes may occur from day to day, or even within a single day.
- Absence of negative symptoms (i.e. affective flattening, alogia or paucity of speech, avolition, asociality, anhedonia) is evident during the psychotic episode.
- The duration of the symptoms does not exceed 3 months, and most commonly lasts from a few days to 1 month.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g. a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g. corticosteroids) – including withdrawal effects (e.g. from alcohol) – and are not better accounted for by schizophrenia or another primary psychotic disorder.

Course specifiers for acute and transient psychotic disorder

The following specifiers should be applied to identify the course of acute and transient psychotic disorder, including whether the individual currently meets the diagnostic requirements for the disorder or is in partial or full remission. If there have been no previous episodes of acute and transient psychotic disorder, the corresponding *single episode* specifier should be applied. If there have been multiple such episodes, the corresponding *multiple episodes* specifier should be applied.

6A23.0 Acute and transient psychotic disorder, first episode

- The *first episode* specifier should be applied when the current or most recent episode is the first manifestation of acute and transient psychotic disorder meeting all diagnostic requirements of the disorder.

6A23.00 Acute and transient psychotic disorder, first episode, currently symptomatic

- All diagnostic requirements for acute and transient psychotic disorder in terms of symptoms and duration are currently met, or have been met within the past month.
- There have been no previous episodes of acute and transient psychotic disorder.

6A23.01 Acute and transient psychotic disorder, first episode, in partial remission

- The full diagnostic requirements for acute and transient psychotic disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been no previous episodes of acute and transient psychotic disorder.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of acute and transient psychotic disorder following an asymptomatic period in a person who has previously met the diagnostic requirements for acute and transient psychotic disorder.

6A23.02 Acute and transient psychotic disorder, first episode, in full remission

- The full diagnostic requirements for acute and transient psychotic disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been no previous episodes of acute and transient psychotic disorder.

6A23.0Z Acute and transient psychotic disorder, first episode, unspecified

6A23.1 Acute and transient psychotic disorder, multiple episodes

The *multiple episodes* specifier should be applied when there have been a minimum of two episodes meeting all diagnostic requirements of acute and transient psychotic disorder in terms of symptoms and duration, with a period of full remission between episodes lasting at least 3 months.

6A23.10 Acute and transient psychotic disorder, multiple episodes, currently symptomatic

- All diagnostic requirements for acute and transient psychotic disorder in terms of symptoms and duration are currently met, or have been met within the past month.
- There have been a minimum of two episodes, with a period of full remission between episodes lasting at least 3 months.

6A23.11 Acute and transient psychotic disorder, multiple episodes, in partial remission

- The full diagnostic requirements for acute and transient psychotic disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.
- There have been a minimum of two episodes, with a period full remission between episodes lasting at least 3 months.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of acute and transient psychotic disorder following an asymptomatic period.

6A23.12 Acute and transient psychotic disorder, multiple episodes, in full remission

- The full diagnostic requirements for acute and transient psychotic disorder have not been met within the past month, and no clinically significant symptoms remain.
- There have been a minimum of two episodes, with a period of full remission between episodes lasting at least 3 months.

6A23.1Z Acute and transient psychotic disorder, multiple episodes, unspecified

6A23.Y Other specified acute and transient psychotic disorder

6A23.Z Acute and transient psychotic disorder, unspecified

Additional clinical features

- The onset of the acute and transient psychotic disorder is usually associated with a rapid deterioration in social and occupational functioning. Following remission, the person is generally able to regain the premorbid level of functioning.
- There are often other symptoms such as fluctuating disturbances of mood and affect, transient states of perplexity or confusion, or impairment of attention and concentration.
- An episode of acute stress preceding the onset of acute and transient psychotic disorder is commonly reported, but this is not a diagnostic requirement.
- If the symptoms last for more than 3 months, a different diagnosis should be considered, depending on the specific symptoms (e.g. schizophrenia, schizoaffective disorder, delusional disorder, other primary psychotic disorder).

Boundary with normality (threshold)

- Isolated unusual subjective experiences, such as experiences resembling hallucinations and delusions, are reported in the general population. However, in acute and transient psychotic disorder, the symptoms progress rapidly to full psychosis; they are usually polymorphic, fluctuating in quality and intensity (e.g. having features come and go in relatively rapid succession, or having the nature of a feature change over time, such as the focus or nature of a delusional belief); and usually fully remit within several weeks.

Course features

- Symptoms are brief in nature, lasting anywhere from a few days but not exceeding 3 months.
- Some individuals diagnosed with acute and transient psychotic disorder will go on to meet diagnostic requirements for another mental disorder, such as schizophrenia, another primary psychotic disorder or a mood disorder.
- In general, favourable outcomes are associated with acute onset, short duration, good premorbid functioning and female gender.

Developmental presentations

- Onset of acute and transient psychotic disorders typically occurs between early and middle adulthood. However, the disorder may occur during adolescence or later in the lifespan, often following an episode of acute stress.

Culture-related features

- Migrant populations may be more likely to report these experiences. This may be due to higher prevalence as a result of migration-related stress, misattribution of psychosis by clinicians unfamiliar with cultural expressions of distress, or a combination of the two.
- In some cultures, distress due to social and other environmental circumstances may be expressed in ways that can be misinterpreted as psychotic symptoms (e.g. overvalued ideas and pseudo-hallucinations) but that instead are normative to the person's subgroup.

Sex- and/or gender-related features

- Acute and transient psychotic disorder is more prevalent among females.
- Male gender and younger age of acute and transient psychotic disorder onset appear to be associated with greater risk of subsequent development of schizophrenia.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia and schizoaffective disorder

The psychotic symptoms in schizophrenia and in schizoaffective disorder last for at least 1 month in their full, florid form and tend to be more stable or fixed (e.g. having the same delusion for a period of months). In contrast, the symptoms in acute and transient psychotic disorder tend to fluctuate rapidly in intensity and type across time, such that the content and focus of delusions or hallucinations often shift, even on a daily basis. Negative symptoms may be present in schizophrenia and schizoaffective disorder, but do not occur in acute and transient psychotic disorder. The duration of acute and transient psychotic disorder does not exceed 3 months, and most often lasts from a few days to 1 month, compared to a much longer typical course for schizophrenia or schizoaffective disorder. Finally, in contrast to schizophrenia, where the onset is often preceded by a history of poor premorbid adjustment, in acute and transient psychotic disorder the person's symptoms progress rapidly without a prodromal period. In cases that meet both the diagnostic requirements for acute and transient psychotic disorder (i.e. fluctuating symptoms, acute onset, duration less than 3 months) and schizophrenia (e.g. delusions and hallucinations for more than 1 month) in the absence of a previous history of schizophrenia, a diagnosis of acute and transient psychotic disorder and not schizophrenia should be assigned.

Boundary with mood disorders with psychotic symptoms

Depressive and bipolar disorders are characterized by a predominant disturbance in mood that persists for at least several days and often much longer. Although mood symptoms may occur in acute and transient psychotic disorder, they are transient and do not meet the required duration or associated symptoms to qualify for a depressive, manic or mixed episode.

Boundary with acute stress reaction and dissociative disorders

Like acute and transient psychotic disorder, acute stress reaction and some dissociative disorders have an acute onset, often in response to a stressful life experience, and resolve in days to weeks. In contrast, by definition, acute and transient psychotic disorder includes psychotic symptoms like hallucinations or delusions that do not occur in disorders specifically associated with stress or in dissociative disorders.

Boundary with delirium

In delirium, the individual has a fluctuating clouding of consciousness (i.e. reduced ability to direct, focus, sustain and shift attention) and awareness (i.e. reduced orientation to the environment). In contrast, in acute and transient psychotic disorder, the person maintains a regular level of alertness and relatively clear sense of consciousness, despite transient states of perplexity, confusion and impairment of attention or concentration.

6A24 Delusional disorder

Essential (required) features

- The presence of a delusion or set of related delusions, typically persisting for at least 3 months and often much longer, in the absence of a depressive, manic or mixed episode is required for diagnosis.
- The delusions are variable in content across individuals, while showing remarkable stability within individuals, although they may evolve over time. Common forms of delusions include persecutory, somatic (e.g. a belief that organs are rotting or malfunctioning despite normal medical examination), grandiose (e.g. a belief that one has discovered an elixir that gives eternal life), jealous (e.g. the unjustified belief that one's spouse is unfaithful) and erotomanic (i.e. the belief that another person, usually a famous or high-status stranger, is in love with the person experiencing the delusion).
- Absence of clear and persistent hallucinations; severely disorganized thinking (formal thought disorder); experiences of influence, passivity or control; or negative symptoms characteristic of schizophrenia is evident. However, in some cases, specific hallucinations typically related to the content of the delusions may be present (e.g. tactile hallucinations in delusions of being infected by parasites or insects).
- Apart from the actions and attitudes directly related to the delusional system, affect, speech and behaviour are typically unaffected.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), are not due to the effects of a substance or medication on the central nervous system (e.g. corticosteroids) – including withdrawal effects (e.g. from alcohol) – and are not better accounted for by another mental disorder (e.g. another primary psychotic disorder, a mood disorder, an obsessive-compulsive or related disorder, an eating disorder).

Course specifiers for delusional disorder

The following specifiers should be applied to identify whether the individual currently meets the diagnostic requirements of delusional disorder or is in partial or full remission.

6A24.0 Delusional disorder, currently symptomatic

- All diagnostic requirements for delusional disorder in terms of symptoms and duration are currently met, or have been met within the past month.

6A24.1 Delusional disorder, in partial remission

- The full diagnostic requirements for delusional disorder have not been met within the past month, but some clinically significant symptoms remain, which may or may not be associated with functional impairment.

Note: this category may also be used to designate the re-emergence of subthreshold symptoms of delusional disorder following an asymptomatic period in a person who has previously met the diagnostic requirements for delusional disorder.

6A24.2 Delusional disorder, in full remission

- The full diagnostic requirements for delusional disorder have not been met within the past month, and no clinically significant symptoms remain.

6A24.Z Delusional disorder, unspecified

Additional clinical features

- Delusions may be accompanied by actions directly related to the content of the delusions – for example, stalking the loved person in the context of erotomania or filing lawsuits against those believed to be persecuting the person.
- Rarely, delusional disorder may occur at the same time (or closely associated in time) in two people who have a strong emotional or situational link. This condition is often referred to as "shared or induced delusional disorder" or "folie-à-deux". In such cases, one person typically adopts the delusional belief of the other person, and the delusions may remit in the less dominant person when the two individuals are separated.

Boundary with normality (threshold)

- A continuum of delusional beliefs, attenuated delusional beliefs, overvalued ideas, and unusual or eccentric beliefs has been observed in the general population. Such beliefs may be more common among people under conditions of adversity. People with delusional disorder may display greater psychological distress, greater preoccupation and a higher degree of conviction compared to people in the general population with beliefs that are similar in nature to beliefs that could be characterized as delusional.

Course features

- Delusional disorder typically has a later onset and greater stability of symptoms than other psychotic disorders with delusional symptoms.
- Some individuals with delusional disorder will develop schizophrenia.
- Individuals are more likely to have a premorbid personality disorder prior to the onset of delusional disorder.
- Levels of functioning are typically better among individuals with delusional disorder compared to those with a diagnosis of schizophrenia or another primary psychotic disorder.
- Individuals with delusional disorder are less likely to require hospitalization in comparison to individuals with either schizophrenia or schizoaffective disorder.

Developmental presentations

- Delusional disorder is more prevalent among older individuals.
- Individuals who experience delusional disorder in early adulthood are more likely to have a history of hallucinations and severe psychopathology during adolescence.

Culture-related features

- Cultural factors may influence the presentation and diagnosis of delusional disorder. For example, spirit possession or witchcraft beliefs may be normative in some but not other cultures.
- Individuals may present with a combination of delusions and overvalued ideas, both drawing on similar cultural idioms and beliefs.
- Diverse populations that experience persecution (e.g. torture, political violence, discrimination due to minority status) may report fears that may be misjudged as paranoid delusions; these may represent instead appropriate fears of recurrence of being persecuted or symptoms of co-occurring post-traumatic stress disorder. Accurate diagnosis relies on obtaining historical information and considering the cultural context to discern the veracity of persecutory beliefs.

Sex- and/or gender-related features

- There are no prominent gender differences in delusional disorder. However, males appear to have a younger age of onset and are more likely to have delusions of jealousy.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia

Both schizophrenia and delusional disorder may be characterized by persistent delusions. If other features are present that meet the diagnostic requirements for schizophrenia (i.e. persistent hallucinations, disorganized thinking, negative symptoms, disorganized or abnormal psychomotor behaviour, or experiences of influence, passivity or control), a diagnosis of schizophrenia may be made instead of a diagnosis of delusional disorder. However, hallucinations that are consistent with the content of the delusions and do not occur persistently (i.e. with regular frequency for 1 month or longer) are consistent with a diagnosis of delusional disorder rather than schizophrenia. Delusional disorder is generally characterized by relatively preserved personality and less deterioration and impairment in social and occupational functioning than schizophrenia, and individuals with delusional disorder tend to present for the first time at a later age. Individuals with symptom presentations consistent with delusional disorder (e.g. delusions and related, circumscribed hallucinations) but who have not met the minimum duration requirement of 3 months should not be assigned a diagnosis of schizophrenia, even though the combination of persistent delusions and related hallucinations technically meets diagnostic requirements for schizophrenia. Instead, a diagnosis of other specified primary psychotic disorder is more appropriate in such cases.

Boundary with mood disorders with psychotic symptoms

In depressive disorders with psychotic symptoms and bipolar disorders with psychotic symptoms, delusions may present during the course of the mood episodes. Although mood symptoms – especially depressed mood – can occur in delusional disorder, the diagnosis of delusional disorder requires that there are times when the person experiences the delusions in the absence of any mood disturbance.

Boundary with obsessive-compulsive disorder, body dysmorphic disorder, hypochondriasis (health anxiety disorder), olfactory reference disorder and anorexia nervosa

A number of mental disorders (e.g. obsessive-compulsive disorder, body dysmorphic disorder, hypochondriasis, olfactory reference disorder, anorexia nervosa) may involve a recurrent preoccupation with a belief that is demonstrably untrue or that is not shared by others (e.g. that ritualistically washing one's hands prevents harm to loved ones, that a body part is defective, that one has a serious medical illness, that one emits a foul smell, that one is overweight) that may at times appear to be delusional in intensity, in the context of the other clinical features of that disorder. An additional diagnosis of delusional disorder should not be given if the belief occurs entirely in the context of symptomatic episodes of one of these other disorders and is fully consistent with its other clinical features.

Boundary with dementia

Delusions – especially persecutory delusions – may occur as a symptom of dementia, particularly among older adults. Such delusions are differentiated from delusional disorder in that they have their onset during the dementia and are, by definition, due to another medical condition or prolonged substance use. In contrast, the delusions in delusional disorder must have had their onset prior to the onset of dementia. In cases where dementia has developed in someone with an established diagnosis of delusional disorder, both diagnoses may be assigned.

Boundary with delirium

Delusions may also be a prominent feature of delirium. In delirium, however, the individual also has a fluctuating clouding of consciousness (i.e. reduced ability to direct, focus, sustain, and shift attention) and awareness (i.e. reduced orientation to the environment). In contrast, in delusional disorder, there is no disturbance of attention or consciousness.

6A2Y Other specified primary psychotic disorder

Essential (required) features

- The presentation is characterized by psychotic symptoms that share primary clinical features with disorders in the schizophrenia and other primary psychotic disorders grouping (e.g. delusions, hallucinations, formal thought disorder, grossly disorganized or catatonic behaviour).
- The symptoms do not fulfil the diagnostic requirements (e.g. in severity, frequency or duration) for any other disorder in the schizophrenia and other primary psychotic disorders grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a mood disorder, a disorder specifically associated with stress, a dissociative disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. corticosteroids), including withdrawal effects (e.g. from alcohol).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6A2Z Schizophrenia or other primary psychotic disorder, unspecified

Specifier scales for symptomatic manifestations of primary psychotic disorders

ICD-11 includes the option of providing a specification of the level of severity for six symptom domains for the disorders included in schizophrenia and other primary psychotic disorders.

These domains are:

6A25.0	Positive symptoms
6A25.1	Negative symptoms
6A25.2	Depressive mood symptoms
6A25.3	Manic mood symptoms
6A25.4	Psychomotor symptoms
6A25.5	Cognitive symptoms

The contribution of each of these symptom domains can be recorded in the form of specifiers, which can be rated as *not present/none* (XS8H), *mild* (XS5W), *moderate* (XS0T) or *severe* (XS25), using the anchor points and descriptions provided in Tables 6.6–6.12 below. The ratings should be made based on the severity of the symptoms corresponding to that domain during the past week.

Each domain that contributes significantly to the individual clinical presentation should be rated. As many symptom specifiers should be applied as necessary to describe the current clinical presentation accurately. A symptom domain can also be recorded with unspecified severity – for example, if symptoms corresponding to a particular domain are present but insufficient information is available in order to rate their severity. In this case, the code for the symptom domain would be recorded (e.g. 6A25.0) without a severity rating.

In cases where multiple symptoms fall within a particular domain, the rating should reflect the *most* severe symptom within that domain. For example, hallucinations and delusions are both part of the positive symptoms domain. A person may experience hallucinations that result in minimal distress (indicative of mild positive symptoms) and delusions that affect the person's behaviour but not to the point of impairing their functioning (indicative of moderate positive symptoms). In that case, the person's positive symptoms should be rated as moderate. Note that individuals with primary psychotic disorders typically do not present with all the symptoms that are part of a given specifier domain. For example, in the positive symptoms domain, a person may present with only hallucinations, only delusions, both or neither. The descriptions corresponding to each rating in the tables below are intended to convey examples of symptom presentations that would justify a rating at a particular level of severity; they are not intended to be used as required criteria.

Note that the mild, moderate and severe ratings for the *depressive mood symptoms* specifier are not equivalent to the corresponding diagnostic requirements for a mild, moderate or severe depressive episode. In other words, a rating of mild for depressive mood symptoms in the psychotic disorder specifiers does not indicate that the individual meets the requirements for a mild depressive episode. The same is true of the *manic mood symptoms* specifier. The rating of depressive and manic mood symptoms in these specifiers indicates the severity of depressed, elevated, or irritable mood, and does not include other symptoms (e.g. disrupted sleep, anhedonia, appetite change) that can occur as a part of mood episodes.

Symptom specifier ratings are intended to characterize the current clinical presentation among individuals diagnosed with schizophrenia and other primary psychotic disorders, and should not be used in individuals without such a diagnosis. Symptoms attributable to the direct pathophysiological consequences of a comorbid medical condition or injury not classified under mental, behavioural and neurodevelopmental disorders (e.g. a brain tumour or traumatic brain injury), or to the direct physiological effects of substances or medications (including withdrawal effects), should not be included in the specifier ratings. However, in individuals with schizophrenia and other primary psychotic disorders, the specific etiology of symptoms is often unclear (e.g. whether a mood symptom is due to the psychotic disorder or a result of substance use). In these cases, the relevant symptom should be considered in making the specifier rating until it becomes clear that the pathogenesis of the symptom is unrelated to the primary psychotic disorder.

Table 6.6. Symptomatic manifestations of primary psychotic disorders: anchor points and descriptions for specifier severity ratings

Severity	Anchor points
None XS8H	No significant symptoms from the respective domain have been present during the past week
Mild XS5W	Symptoms in the domain have been present during the past week, but these are minimal in number or do not have a substantial degree of impact. Everyday functioning is not affected by these symptoms, or is affected only minimally. No significant negative social or personal consequences have occurred as a consequence of the symptoms. The symptoms may be intermittent and show fluctuations in severity, and there may be periods during which the symptoms are absent. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the mildest third.
Moderate XS0T	A greater number of symptoms in the domain have been present during the past week, or a smaller number of symptoms that have a substantial degree of impact. Everyday functioning may be moderately affected by the symptoms. There are negative social or personal consequences of the symptoms, but these are not severe. Most of the symptoms are present the majority of the time. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the middle third.
Severe XS25	Many symptoms in the domain have been present during the past week, or a smaller number that have a severe or pervasive degree of impact (i.e. they are intense and frequent or constant). Everyday functioning is persistently impaired due to the symptoms. There are serious negative social or personal consequences. Compared to other individuals with similar symptoms, the severity of symptoms in the domain is in the most severe third.
Severity unspecified	Symptoms from the respective domain have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.0 Positive symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the degree to which positive psychotic symptoms are a prominent part of the current clinical presentation (see Table 6.7). Positive symptoms include delusions, hallucinations (most commonly verbal auditory hallucinations), disorganized thinking (formal thought disorder such as loose associations, thought derailment or incoherence), disorganized behaviour (behaviour that appears bizarre, purposeless and not goal-directed), and experiences of passivity and control (the experience that one's feelings, impulses or thoughts are under the control of an external force). Abnormal psychomotor behaviour (e.g. catatonic restlessness or agitation, waxy flexibility, negativism) is not included in this domain but instead would be rated in the 6A25.4 Psychomotor symptoms domain below.

The rating should be made based on the severity of positive symptoms during the past week.

Table 6.7. Rating scale for positive symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.0&XS8H	No significant positive symptoms have been present during the past week
Mild 6A25.0&XS5W	*Example symptoms (not all are required)* **Delusions** The person believes the delusion (lack of reality testing), but does not feel pressure to act upon it, and the delusion leads to minimal distress. **Hallucinations** Hallucinations are recurrent but relatively infrequent, and the person expresses only minimal distress regarding their content. **Experiences of passivity and control** Some distortions of self-experience are present, such as feeling that one's thoughts are not one's own, but these are relatively infrequent and there is only minimal associated distress. **Disorganized thinking** Some circumstantial or tangential thought processes are present, but for the most part the individual is able to convey the point of the intended communication. **Disorganized behaviour** Infrequent episodes of purposeless behaviour that is not goal-directed and causes only minimal impairment in functioning are present.
Moderate 6A25.0&XS0T	*Example symptoms (not all are required)* **Delusions** The person's behaviour is clearly affected by the delusional beliefs but the person's behavioural response does not significantly impair functioning (e.g. a person with persecutory delusions is watchful of their surroundings but continues to venture outside). **Hallucinations** Hallucinations are relatively frequent and may be distressing at times but are tolerated at other times, and do not persistently preoccupy the person. The content of hallucinations may prompt action, but the person only inconsistently or occasionally responds, and these actions do not put the person or others at risk of harm.

Table 6.7. contd

Severity	Anchor points
	Experiences of passivity and control Distortions of self-experience are relatively frequent and lead to some behaviours to ward against alteration of thoughts (e.g. superstitious rituals) or noticeable distress. **Disorganized thinking** Evidence of frequent circumstantial or tangential thought process that impairs the individual's ability to convey the point of the communication. **Disorganized behaviour** Frequent episodes of purposeless behaviour that is not goal-directed and that causes some impairment in functioning.
Severe 6A25.0&XS25	*Example symptoms (not all are required)* **Delusions** The person is preoccupied with delusional beliefs that dictate many of their actions and significantly impair functioning (e.g. a person with persecutory delusions refuses to eat most food because of a conviction that food has been poisoned). **Hallucinations** The person is markedly distressed or preoccupied by frequent hallucinations, or there are recurrent hallucinations that prompt potentially harmful behaviour to which the person feels compelled to respond. **Experiences of passivity and control** Distortions of self-experience are markedly distressing, and significantly affect the individual's behaviour (e.g. wearing a hat made of aluminium foil to prevent thought broadcasting). **Disorganized thinking** Loose associations in thought processes are present that are so severe that speech is mostly incoherent. **Disorganized behaviour** Purposeless behaviour that is not goal-directed dominates the individual's behavioural repertoire, and causes severe impairment in functioning.
Severity unspecified 6A25.0	Positive symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.1 Negative symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the degree to which negative psychotic symptoms are a prominent part of the current clinical presentation (see Table 6.8). Negative symptoms include constricted, blunted or flat affect; alogia or paucity of speech; avolition (general lack of drive, or lack of motivation to pursue meaningful goals); asociality (reduced or absent engagement with others and interest in social interaction) and anhedonia (inability to experience pleasure from normally pleasurable activities). To be considered negative psychotic symptoms, relevant symptoms should not be entirely attributable to depression or to an understimulating environment, be a direct consequence of a positive symptom (e.g. persecutory delusions causing a person to become socially isolated due to fear of harm), or be attributable to the direct physiological effects of substances or medications, including withdrawal effects. Catatonia, including catatonic mutism, should be considered as part of the 6A25.4 Psychomotor symptoms domain below rather than here.

The rating should be made based on the severity of negative symptoms during the past week.

Table 6.8. Rating scale for negative symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.1&XS8H	No significant negative symptoms have been present during the past week.
Mild 6A25.1&XS5W	*Example symptoms (not all are required)* Blunted emotional experience or expression is present, with subtle but detectable affective changes. Initiation of speech is limited, but the individual is responsive to questions. The person shows little interest in external events, but exhibits sufficient motivation to engage in basic activities of daily living or to complete a task when prompted
Moderate 6A25.1&XS0T	*Example symptoms (not all are required)* Flat emotional expression is present. Initiation of speech for purposes other than indicating immediate needs and desires is minimal, but the individual is responsive to questions with terse phrases. Lack of volition leads to neglect of hygiene or required activities, but the person will complete them with significant prompting.
Severe 6A25.1&XS25	*Example symptoms (not all are required)* The person reports feeling empty or robotic most of the time. Generally the individual does not initiate speech, even to indicate immediate needs and desires. The person is not capable of initiating behaviour even with significant prompting, which may lead to serious neglect of self-care to the extent that it puts the person at risk of harm (e.g. infrequently taking life-sustaining medication).
Severity unspecified 6A25.1	Negative symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.2 Depressive mood symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the degree to which depressive mood symptoms are a prominent part of the current clinical presentation (see Table 6.9). The specifier refers only to depressive mood symptoms, as reported by the individual (feeling down, sad) or as observed by the clinician (e.g. tearful, defeated appearance). The severity of associated non-mood symptoms of a depressive episode (e.g. anhedonia or other negative symptoms, changes in sleep or appetite) should not be considered in making a rating for this specifier. In this regard, the *depressive mood symptoms* specifier is different from the severity rating applied to a depressive episode (see p. 216). If suicidal ideation is present, a rating of moderate or severe depressive mood symptoms should automatically be applied (see below). This specifier may be used regardless of whether the depressive symptoms meet the diagnostic requirements for a depressive episode.

The rating should be made based on the severity of depressive mood symptoms during the past week.

Table 6.9. Rating scale for depressive mood symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.2&XS8H	No significant depressive mood symptoms have been present during the past week
Mild 6A25.2&XS5W	The person expresses significant depressed mood, but there are intermittent periods of relief. The depressive symptoms have some, but not considerable, impact on at least some areas of personal, social or occupational functioning.
Moderate 6A25.2&XS0T	The depressed mood is present continually, although its intensity may vary. Suicidal ideation may accompany the depressed mood when it is more intense. The depressive symptoms cause considerable difficulty with personal, social or occupational functioning.
Severe 6A25.2&XS255	The intensity of the depressed mood is overwhelming to the person. This level of severity may be indicated by intense suicidal ideation or suicide attempts. The depressive symptoms seriously affect all areas of functioning (personal, social and occupational) to such an extent that the person is unable to function, except to a very limited degree.
Severity unspecified 6A25.2	Depressive mood symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.3 Manic mood symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the extent to which manic mood symptoms are a prominent part of the clinical presentation (see Table 6.10). The specifier includes elevated, euphoric, irritable or expansive mood states, including rapid changes among different mood states (i.e. mood lability). It also includes increased subjective experience of energy, which may be accompanied by increased goal-directed activity. The severity of associated non-mood symptoms of a manic or hypomanic episode (e.g. decreased need for sleep, distractibility) should not be considered in making a rating for this specifier. Increased non-goal-directed psychomotor activity should be considered as part of the 6A25.4 Psychomotor symptoms domain below rather than here. This specifier may be used regardless of whether the manic symptoms meet the diagnostic requirements for a manic episode.

The rating should be made based on the severity of manic mood symptoms during the past week.

Table 6.10. Rating scale for manic mood symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.3&XS8H	No significant manic mood symptoms have been present during the past week.
Mild 6A25.3&XS5W	Hypomanic elevation of mood or increased irritability is present. The hypomanic symptoms do not cause marked impairment in personal, social or occupational functioning.
Moderate 6A25.3&XS0T	Marked elevation of mood, irritability or subjective energy level is present. The manic symptoms cause considerable difficulty with personal, social or occupational functioning.
Severe 6A25.3&XS25	Extreme elevation of mood or irritability is present that results in hazardous, dangerous or markedly inappropriate behaviour to a degree that intensive supervision is required.
Severity unspecified 6A25.3	Manic mood symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.4 Psychomotor symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the degree to which psychomotor symptoms are a prominent part of the clinical presentation (see Table 6.11). Psychomotor symptoms include psychomotor agitation or increased motor activity, usually manifested in purposeless behaviours such as fidgeting, shifting, fiddling, inability to sit or stand still, wringing of the hands, stereotypy and grimacing. Psychomotor symptoms also include psychomotor retardation (a visible generalized slowing of movements and speech), as well as catatonic symptoms such as extreme restlessness with purposeless motor activity to the point of exhaustion, posturing, waxy flexibility, negativism, mutism or stupor. To be considered psychomotor symptoms for the purpose of this specifier rating, symptoms should not be attributable to a neurodevelopmental disorder or disease of the nervous system, or to the direct physiological effects of substances or medications, including withdrawal effects. If the full syndrome of catatonia is present, the diagnosis of 6A40 Catatonia associated with another mental disorder (p. 202) should also be assigned.

The rating should be made based on the severity of psychomotor symptoms during the past week.

Table 6.11. Rating scale for psychomotor symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.4&XS8H	No significant psychomotor symptoms have been present during the past week
Mild 6A25.4&XS5W	The majority of the time the person exhibits a normal level of activity, but there are occasional periods of psychomotor excitation or slowing. Psychomotor symptoms do not interfere significantly with important personal, social or occupational functioning.
Moderate 6A25.4&XS0T	The person experiences frequent periods of marked psychomotor agitation or retardation, but psychomotor symptoms are not continuous. Psychomotor symptoms interfere significantly with important personal, social or occupational functioning.
Severe 6A25.4&XS25	The individual experiences severe and nearly continuous psychomotor agitation or slowing, which may include the full syndrome of catatonia (see p. 202). The psychomotor symptoms are sufficiently severe to be potentially harmful to the person or others (e.g. agitation to the point of severe physical exhaustion, stupor that prevents the person from feeding themselves).
Severity unspecified 6A25.4	Psychomotor symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

6A25.5 Cognitive symptoms

This specifier may be used together with a diagnosis from the grouping of schizophrenia and other primary psychotic disorders to indicate the degree to which cognitive impairment is a prominent aspect of the clinical presentation (see Table 6.12). Deficits may appear in any of the following cognitive domains: speed of processing, attention/concentration, orientation, judgement, abstraction, verbal or visual learning, or working memory. The cognitive impairment is not attributable to a neurodevelopmental disorder, to delirium or another neurocognitive disorder, or to the direct effects of a substance or medication on the central nervous system, including withdrawal effects. When available, the severity rating for this domain should be based on the results of locally validated, standardized neuropsychological assessments, but such measures are not available in all settings and are not required to provide a rating.

The rating should be made based on the severity of cognitive symptoms during the past week.

Table 6.12. Rating scale for cognitive symptoms in primary psychotic disorders

Severity	Anchor points
None 6A25.5&XS8H	No significant cognitive symptoms have been present during the past week
Mild 6A25.5&XS5W	The person has minor difficulties in cognition (e.g. difficulty with recall during the interview, drifting concentration, showing some disorientation to time but not person or place). Everyday functioning is largely unimpaired by the difficulties
Moderate 6A25.5&XS0T	The individual shows clear difficulties in cognition (e.g. impaired or inconsistent recall for some autobiographical information, inability to perform some basic operations that are expected of the person's educational attainment and level of intellectual functioning – such as simple calculation tasks, disrupted orientation for time and place but intact for person, difficulty learning or retaining new information). Everyday functioning is impaired as a result, but only some external assistance is necessary.
Severe 6A25.5&XS25	The person shows pronounced difficulties in cognition (e.g. severe deficits in verbal memory or other cognitive tasks relative to educational attainment and level of intellectual functioning, substantial difficulty with concentration and paying attention to what the rater asks during the interview, difficulty formulating plans to accomplish a specific objective, inability to consider alternative solutions to problems, grossly disturbed orientation). The problems severely interfere with everyday functioning, leading to the necessity of considerable external assistance.
Severity unspecified 6A25.5	Cognitive symptoms have been present during the past week, but it is not possible to make a severity rating based on the available information.

Catatonia

Catatonia is a syndrome of primarily psychomotor disturbances, characterized by the co-occurrence of several symptoms of decreased, increased or abnormal psychomotor activity. The assessment of catatonia is complex and requires observation, interview and physical examination. Catatonia can occur in the context of other mental disorders, such as schizophrenia and other primary psychotic disorders, mood disorders and neurodevelopmental disorders – especially autism spectrum disorder. Catatonia can also develop during or soon after intoxication or withdrawal from certain psychoactive substances, including phencyclidine (PCP), cannabis, hallucinogens such as mescaline or lysergic acid diethylamide (LSD), cocaine and MDMA or related drugs, or during the use of certain psychoactive and non-psychoactive medications (e.g. antipsychotic medications, benzodiazepines, steroids, disulfiram, ciprofloxacin). Finally, catatonia can occur as a direct pathophysiological consequence of a medical condition not classified under mental, behavioural and neurodevelopmental disorders. Examples of medical conditions that may be associated with catatonia include diabetic ketoacidosis, hypercalcaemia, hepatic encephalopathy, homocystinuria, neoplasms, head trauma, cerebrovascular disease and encephalitis.

Catatonia includes the following:

6A40	Catatonia associated with another mental disorder
6A41	Catatonia induced by substances or medications
6E69	Secondary catatonia syndrome
6A4Z	Catatonia, unspecified

The category of secondary catatonia syndrome is a part of the grouping of secondary mental or behavioural syndromes associated with disorders or diseases classified elsewhere. Is is listed here, with diagnostic guidance provided, because of its diagnostic commonality with other forms of catatonia.

Below are the general diagnostic requirements for catatonia, which apply to all four catatonia categories, followed by the essential features, additional clinical features (if applicable) and course features for each of the three specified types of catatonia listed above. After that, additional CDDR sections (developmental presentations, culture-related features, and boundaries with other disorders and conditions) are provided for all types of catatonia together.

General diagnostic requirements for catatonia

Essential (required) features

- The presence of three or more of the following symptoms of decreased, increased or abnormal psychomotor activity is required for diagnosis. The three symptoms may come from one or any combination of the following three symptom clusters. ***Note:*** symptoms that require assessment by physical examination are indicated below.

Decreased psychomotor activity

- Staring: fixed gaze; decreased blinking, often with widely opened eyes
- Ambitendency: appearance of being "motorically stuck" in indecisive or hesitant movement
- Negativism: opposing or behaving contrary to requests or instructions, which may lead to withdrawal from interaction with others (turning away) or refusal to take food or drink when offered
- Stupor: immobility; no or markedly reduced psychomotor activity; minimally responsive to external stimuli
- Mutism: no or very little verbal response; speech that is hushed or whispered to the point of being unintelligible (***Note:*** do not count if speech symptoms are due to a disease of the nervous system, developmental speech or language disorder, or other disease or disorder affecting speech.)

Increased psychomotor activity

- Any of the following: extreme hyperactivity or agitation for no reason with nonpurposeful movements and/or uncontrollable, extreme emotional reactions; impulsivity (sudden engagement in inappropriate behaviour without provocation); combativeness (striking out against others usually in an undirected manner, with or without the potential for injury) (***Note:*** multiple manifestations of increased psychomotor activity should only be counted as one of the required three symptoms in order to meet the requirements for catatonia.)

Abnormal psychomotor activity

- Grimacing: odd or distorted facial expressions; often inappropriate and irrelevant to the situation
- Mannerisms: odd, purposeful movements that are not appropriate to the individual's cultural context; exaggerated caricatures of mundane movements
- Posturing: spontaneous and active maintenance of a posture against gravity; sitting or standing for long periods without reacting
- Stereotypy: repetitive, non-goal-directed motor activity (e.g. finger-play, repeatedly touching, patting or rubbing self) (***Note:*** the abnormality is not inherent in the action but relates to its frequency.)
- Rigidity: resistance by way of increased muscle tone, which may range in severity from mildly increased tone to severe "lead pipe" rigidity (requires examination)
- Echophenomena: mimicking examiner's speech (echolalia) or movements (echopraxia)
- Verbigeration: continuous and directionless repetition of words, phrases or sentences
- Waxy flexibility: slight and even resistance to positioning by examiner (requires examination)

  - Catalepsy: passive induction of a posture (typically as examiner passively moves patient's extremity), which remains held against gravity (requires examination)
- The symptoms typically last for at least several hours but can persist much longer. For some severe items (e.g. stupor, catalepsy, mutism, negativism) or if vital sign (autonomic) abnormality is present, a short duration (e.g. 15 minutes) may be sufficient to be considered a qualifying symptom.
- The symptoms result in significant impairment in daily functioning or are severe enough to cause serious medical complications (e.g. contractures, exhaustion, dehydration, aspiration) or risk of death resulting from autonomic abnormalities or complications (e.g. rigidity leading to renal failure from rhabdomyolysis).
- The symptoms are not better accounted for by a primary movement disorder classified in Chapter 8 on diseases of the nervous system.

Specifiers for autonomic abnormalities in catatonia

Catatonia may be accompanied by vital sign abnormalities not fully accounted for by a comorbid medical condition that may signal potentially life-threatening complications and therefore require immediate attention. These include tachycardia or bradycardia; hypertension or hypotension; and hyperthermia or hypothermia. In these cases, as many of the following symptom codes as applicable should be applied:

MG26	Fever of other or unknown origin
MG28	Hypothermia, not associated with low environmental temperature
MC80.0	Elevated blood-pressure reading, without diagnosis of hypertension
MC80.1	Nonspecific low blood-pressure reading
MC81.0	Tachycardia, unspecified
MC81.1	Bradycardia, unspecified.

6A40 Catatonia associated with another mental disorder

Essential (required) features

- The general diagnostic requirements for catatonia are met.
- The catatonic symptoms develop in the context of another mental disorder, such as schizophrenia or another primary psychotic disorder, a mood disorder or autism spectrum disorder.
- The symptoms are not fully accounted for by delirium, the effects of a medication or substance – including withdrawal effects – or a primary movement disorder classified in Chapter 8 on diseases of the nervous system (e.g. Parkinson disease, Huntington disease).
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Note: the associated mental disorder should be diagnosed separately.

Course features

- Acute episodes of catatonia associated with another mental disorder typically develop rapidly within hours or days from single symptoms to full presentation.
- In catatonia associated with another mental disorder, symptoms most commonly resolve within 4 weeks, although some episodes (e.g. in the context of acute psychosis) may remit spontaneously within hours. However, symptoms may also persist for months or even years with little variation of the clinical presentation and severity.
- The individual may experience recurrent episodes of catatonia of several weeks' duration that remit and recur throughout the course of the associated disorder. Most commonly, these catatonia episodes occur during some but not all of the episodes of the associated mental disorder (e.g. a bipolar disorder). Early signs of recurring episodes may include ambitendency or psychomotor slowing.
- Persistent catatonia is most commonly associated with neurodevelopmental disorders or schizophrenia and other primary psychotic disorders. Adolescent onset is more frequent in these cases. Disturbances of volition – such as negativism, mannerisms or stereotyped movements – are more common in persistent catatonia, whereas stupor rarely persists over weeks. In some severe cases, persistent catatonia is characterized by severe, stable symptoms and massive global dysfunction for multiple years.

6A41 Catatonia induced by substances or medications

Essential (required) features

- The general diagnostic requirements for catatonia are met.
- The catatonic symptoms develop during or soon after intoxication with or withdrawal from a specified psychoactive substance, or use of a medication. Substances that may be associated with catatonia include opioids, PCP, cannabis, cocaine, MDMA or related drugs, and hallucinogens such as mescaline or LSD. Catatonia may also be associated with certain psychoactive and non-psychoactive medications (e.g. antipsychotic medications, benzodiazepines, steroids, disulfiram, ciprofloxacin).
- The intensity or duration of the catatonic symptoms is substantially in excess of similar symptoms that are characteristic of intoxication or withdrawal due to the specified substance (e.g. stupor during opioid intoxication; psychomotor agitation and autonomic hyperactivity during alcohol withdrawal).
- The specified substance, as well as the amount and duration of its use, must be capable of producing catatonic symptoms.
- The symptoms are not fully accounted for by delirium or another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder or autism spectrum disorder), and are not the direct pathophysiological consequence of a medical condition.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Course features

- The onset of catatonia induced by substances or medications is typically rapid, often with fast deterioration. The duration of catatonia strongly depends on the inducing substance. Catatonia is more often induced by substance withdrawal than intoxication. Once the effects of the substance or medication (including a withdrawal syndrome) have subsided, catatonia typically remits within days.

6E69 Secondary catatonia syndrome

Essential (required) features

- The general diagnostic requirements for catatonia are met.
- The catatonic symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings. This judgement depends on establishing that:
  - the medical condition is known to be capable of producing the symptoms of catatonia;
  - the course of the catatonic symptoms (e.g. onset, remission, response of the symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition;
  - the symptoms are not fully accounted for by delirium, another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder or autism spectrum disorder), the effects of a medication or substance – including withdrawal effects – or a primary movement disorder classified in Chapter 8 on diseases of the nervous system (e.g. Parkinson disease, Huntington disease).
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Additional clinical features

- Catatonia symptoms that often cluster together in critically ill adults with secondary catatonia include mutism, staring and immobility.

Course features

- The onset of secondary catatonia syndrome is related to the underlying medical condition, and duration is also determined by the underlying medical condition and its treatment.
- In cases in which the underlying disease course is severe and progressive (e.g. Alzheimer disease), secondary catatonia syndrome due to a disease of the nervous system or other medical condition may be chronic (lasting for weeks or months) and may fail to resolve fully with treatment of the underlying medical condition.

Potentially explanatory medical conditions

The identified etiological medical condition should be diagnosed separately.

Medical conditions that have been shown to be capable of producing catatonia syndromes include the following.

Primary brain disorders (examples)

- Neoplasms
- Cerebrovascular lesions, including cortical venous thrombosis, subarachnoid haemorrhage, subdural haematoma, bacillar aneurysms
- Anoxias, including stroke
- Viral encephalitis, encephalitis lethargica
- Brain stem, diencephalic and basal ganglia disorders, as well as frontal lobe or parietal lobe lesions
- Epilepsy
- Traumatic brain injury
- Dystonia
- Multiple sclerosis
- Parkinson disease
- Lewy body disease
- Human prion diseases

General medical conditions affecting the brain (examples)

- Autoimmune conditions
  - Systemic lupus erythematosus
  - Hashimoto encephalopathy or autoimmune encephalitis
- Infectious diseases
  - Typhoid fever
  - Infectious mononucleosis
  - Paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS)
  - HIV/AIDS

- Genetic conditions
  - Prader-Willi syndrome
  - Fatal familial insomnia
  - Tay-Sachs disease
  - Wilson disease

- Metabolic conditions
  - Hypercalcaemia from a parathyroid adenoma
  - Hepatic encephalopathy
  - Homocystinuria
  - Diabetic ketoacidosis
  - Acute intermittent porphyria
  - Membranous glomerulonephritis
  - Hyponatraemia
  - Hypo- and hyperthyroidism
  - Hypo- and hyperadrenalism

- Nutritional deficiencies
  - Pellagra
  - Nicotinic acid deficiency
  - Wernicke's encephalopathy (thiamine deficiency)
  - Vitamin B_{12} deficiency

6A4Z Catatonia, unspecified

Developmental presentations for catatonia (all types)

- Catatonia may occur throughout the entire lifespan, but rarely develops before adolescence. However, severe cases in children aged 8–11 years have been reported.
- Early onset of catatonia (before age 20) is associated with underlying medical conditions, particularly diseases of the nervous system, or neurodevelopmental disorders (e.g. autism spectrum disorder).
- Secondary catatonia syndrome or catatonia induced by substances or medications is more likely to occur after age 40; risk increases considerably after age 65.
- In medically ill adults, the prevalence of secondary catatonia syndrome increases with age and is strongly associated with co-occurring delirium or coma.

Culture-related features for catatonia (all types)

- The incidence of catatonia appears to vary across cultures, and may occur in some cases in reaction to an overwhelming traumatic experience. Catatonia may be more frequent in some immigrant minority communities (e.g. refugees), including in children, where it may be associated with post-traumatic stress disorder and depressive disorders.

Boundaries with other disorders and conditions (differential diagnosis) for catatonia (all types)

Boundary of catatonia induced by substances or medications with other types of catatonia

Evidence supporting a diagnosis of non-substance-induced catatonia would include catatonic symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder that may be associated with catatonic symptoms.

Boundary of catatonia associated with another mental disorder with psychomotor retardation in depressive or mixed episodes

Psychomotor retardation in depressive episodes and decreased psychomotor activity in catatonia can manifest in similar ways. In the presence of a depressive or mixed episode, an additional diagnosis of catatonia associated with another mental disorder is appropriate if symptoms of increased psychomotor activity or abnormal psychomotor activity are also present. If all catatonia symptoms are from the decreased psychomotor activity cluster, whether or not an additional diagnosis of catatonia associated with another mental disorder is assigned is a clinical judgement based on the severity of the symptoms and on whether catatonia is a specific focus of clinical attention.

Boundary of catatonia associated with another mental disorder with psychomotor agitation in depressive, manic or mixed episodes

Psychomotor agitation in a mood episode and increased psychomotor activity in catatonia can manifest in similar ways. In the presence of a mood episode, an additional diagnosis of catatonia associated with another mental disorder is only appropriate if symptoms of decreased psychomotor activity or abnormal psychomotor activity are also present. If all catatonia symptoms are aspects of increased psychomotor activity, an additional diagnosis of catatonia is not warranted.

Boundary of catatonia induced by substances or medications and secondary catatonia with delirium due to psychoactive substances, including medications, with delirium due to disease classified elsewhere

Both delirium and catatonia may be characterized by increased or decreased psychomotor activity. They are distinguished primarily by the disturbance of attention, awareness and arousal – as well as impairment in other cognitive domains – that characterize delirium and are not features of catatonia and the impairment of volition (e.g. ambitendency, negativism, mannerisms) and abnormal muscle tone (rigidity, waxy flexibility, catalepsy) that may occur in catatonia but not delirium.

Boundary of catatonia with autonomic abnormality with neuroleptic malignant syndrome

Symptoms of neuroleptic malignant syndrome include high fever, muscle stiffness, altered mental status and autonomic dysfunction (e.g. wide swings of blood pressure, excessive sweating, excessive secretion of saliva), most of which may also occur in catatonia with autonomic abnormality. A diagnosis of neuroleptic malignant syndrome is based on the clinical judgement that exposure to an antipsychotic medication or other dopamine receptor-blocking agents is the cause of the symptoms. This distinction can be difficult because many individuals who develop catatonia take antipsychotic medication. It is made based on the timing of the symptoms in relation to medication use, prior history of multiple episodes of catatonia (in which case neuroleptic malignant syndrome is less likely), and sometimes the presence of certain medical complications that are not characteristic of catatonia, such as hyperkalaemia or liver or kidney failure.

Boundary of catatonia with serotonin syndrome

Symptoms of serotonin syndrome include agitation or restlessness and muscle rigidity, as well as autonomic disturbances such as high fever and tachycardia, which may also occur in catatonia. A diagnosis of serotonin syndrome involves the clinical judgement that exposure to a serotonergic medication or an interaction between serotonergic medications (e.g. when increasing the dose of a medication or adding a new medication) is the cause of the symptoms, based on the timing of the symptoms in relation to medication use. Serotonin syndrome is more likely to present with tremor, hyperactive muscle reflexes (including clonus) and nystagmus than catatonia. However, the presence of these symptoms does not exclude the possibility of co-occurring catatonia.

Boundary of catatonia with malingering or factitious disorder

Malingering and factitious disorder are both diagnosed based on evidence of feigning of symptoms, which may include catatonic symptoms. Evidence for feigning often includes the observation that the symptoms occur only when the person is being watched. However, disturbances of volition in catatonia (e.g. negativism) may only become apparent during social interactions, which should not by itself be interpreted as evidence of feigning.

Mood disorders

Mood disorders is a superordinate grouping of bipolar disorders and depressive disorders. Mood disorders are defined according to particular types of mood episodes and their pattern over time.

The primary types of mood episodes are:

depressive episode
manic episode
mixed episode
hypomanic episode.

Mood episodes are not independently diagnosable entities, and therefore do not have their own diagnostic codes. Rather, mood episodes are the components of bipolar and related disorders and depressive disorders.

Bipolar and related disorders include the following:

6A60	Bipolar type I disorder
6A61	Bipolar type II disorder
6A62	Cyclothymic disorder
6A6Y	Other specified bipolar or related disorder
6A6Z	Bipolar or related disorder, unspecified.

Depressive disorders include the following:

6A70	Single episode depressive disorder
6A71	Recurrent depressive disorder
6A72	Dysthymic disorder
6A73	Mixed depressive and anxiety disorder
6A7Y	Other specified depressive disorder
6A7Z	Depressive disorder, unspecified.

CDDR are also provided for GA34.41 Premenstrual dysphoric disorder in the section on depressive disorders. Premenstrual dysphoric disorder is classified in the grouping of premenstrual disturbances in Chapter 16 on diseases of the genitourinary system, but is cross-listed here for reference.

GA34.41 Premenstrual dysphoric disorder

A category for mood disorders that do not fit the descriptions for any of the above categories is also provided (other specified), as is a category for use when it is not possible to make a more definitive diagnosis (unspecified):

6A8Y Other specified mood disorder

6A8Z Mood disorder, unspecified

The sections that follow describe the characteristics of mood episodes. After that, the CDDR are provided for the diagnostic categories of mood disorders.

Mood episode descriptions

Depressive episode

Essential (required) features

- The concurrent presence of at least five of the following characteristic symptoms occurring for most of the day, nearly every day, during a period lasting at least 2 weeks is required for diagnosis. At least one symptom from the *affective cluster* must be present. Assessment of the presence or absence of symptoms should be made relative to typical functioning of the individual.

  Affective cluster
  - Depressed mood as reported by the individual (e.g. feeling down, sad) or as observed (e.g. tearful, defeated appearance) (***Note:*** in children and adolescents depressed mood can manifest as irritability.)
  - Markedly diminished interest or pleasure in activities, especially those normally found to be enjoyable to the individual (***Note:*** this may include a reduction in sexual desire.)

  Cognitive-behavioural cluster
  - Reduced ability to concentrate and sustain attention on tasks, or marked indecisiveness
  - Beliefs of low self-worth or excessive and inappropriate guilt that may be manifestly delusional (***Note:*** this item should not be considered present if guilt or self-reproach is exclusively about being depressed.)
  - Hopelessness about the future
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation (with or without a specific plan), or evidence of attempted suicide

Neurovegetative cluster

- Significantly disrupted sleep (delayed sleep onset, increased frequency of waking during the night, or early morning awakening) or excessive sleep
- Significant change in appetite (diminished or increased) or significant weight change (gain or loss)
- Psychomotor agitation or retardation (observable by others, not merely subjective feelings of restlessness or being slowed down)
- Reduced energy, fatigue or marked tiredness following the expenditure of only a minimum of effort

- The symptoms are not better accounted for by bereavement.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants).
- The clinical presentation does not fulfil the diagnostic requirements for a mixed episode.
- The mood disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- In some individuals, the affective component of a depressive episode may be primarily experienced and expressed as irritability, or as an absence of emotional experience (e.g. "emptiness"). These variants in the expression of the affective component can be considered as meeting the depressed mood requirement for a depressive episode if they represent a significant change from the individual's typical functioning.
- In some individuals – particularly those experiencing a severe depressive episode – there may be reluctance to describe certain experiences (e.g. psychotic symptoms) or inability to do so in detail (e.g. due to psychomotor agitation or retardation). In such cases, observations made by the clinician or reported by a collateral informant are important in determining the diagnostic status and severity of the episode.
- Depressive episodes may be associated with increased consumption of alcohol or other substances, exacerbation of pre-existing psychological symptoms (e.g. phobic or obsessional symptoms) or somatic preoccupations.

Boundary with normality (threshold)

- Some depression of mood is a normal reaction to severe adverse life events and problems (e.g. divorce, job loss), and is common in the community. A depressive episode is differentiated from this common experience by the severity, range and duration of symptoms. If the diagnostic requirements for a depressive episode listed above are met, a depressive episode should still be considered present, even if there are identifiable life events that appear to have triggered the episode.

- A depressive episode should not be considered to be present if the individual is exhibiting normal grief symptoms, including some level of depressive symptoms, and the individual has experienced the death of a loved one within the past 6 months, or longer if a more extended period of bereavement is consistent with the normative response for grieving within the individual's religious and cultural context. Individuals with no history of depressive episodes may experience depressive symptoms during bereavement, but this does not appear to indicate an increased risk of subsequently developing a mood disorder. However, a depressive episode can be superimposed on normal grief. The presence of a depressive episode during a period of bereavement is suggested by persistence of constant depressive symptoms 1 month or more following the loss (i.e. there are no periods of positive mood or enjoyment of activities); severe depressive symptoms, such as extreme beliefs of low self-worth and guilt not related to the lost loved one; or presence of psychotic symptoms, suicidal ideation or psychomotor retardation. A prior history of depressive disorder or bipolar disorder is important to consider in making this distinction.

Developmental presentations

- Depressive episodes are relatively rare in childhood, and occur with similar frequency among boys and girls. Rates increase significantly after puberty, and girls are approximately twice as likely as boys to experience a depressive episode.
- All the characteristic features of a depressive episode can be observed in children and adolescents. As in adults, symptoms of a depressive episode should represent a change from prior functioning. Assessment of a depressive episode in younger children in particular is likely to rely on the report of other informants (e.g. parents) regarding signs and symptoms and the extent to which these represent a change from prior functioning.

Affective cluster

- In young children, depressed mood may present as somatic complaints (e.g. headaches, stomach pains), whining, increased separation anxiety or excessive crying. Depressed mood may sometimes present in children and adolescents as pervasive irritability. However, the presence of irritability is not in and of itself indicative of a depressive episode and may indicate the presence of another mental, behavioural or neurodevelopmental disorder, or be a normal reaction to frustration.

Cognitive-behavioural cluster

- As noted, reduced ability to concentrate or sustain attention may manifest as a decline in academic performance, increased time needed to complete school assignments or an inability to complete assignments. These symptoms of a depressive episode must be differentiated from problems with attention and concentration in attention deficit hyperactivity disorder that are not temporally tied to changes in mood or energy.

Neurovegetative cluster

- Hypersomnia and hyperphagia are more common symptoms of a depressive episode in adolescents than in adults. Appetite disturbance in children and adolescents may manifest in failure to gain weight as expected for age and development rather than as weight loss.
- As with adults, children and adolescents experiencing a depressive episode are at increased risk of suicidality. In younger children, suicidality may manifest in passive statements (e.g. "I don't want to be here any more") or as themes of death during play, whereas adolescents may make more direct statements regarding their desire to die.

- Self-injurious behaviours that are not explicitly suicidal in terms of lethality or expressed intent may also occur in a depressive episode in young children and adolescents. Examples include head banging or scratching in young children and cutting or burning in adolescents. If unaddressed, these types of behaviours tend to increase in frequency and intensity over time among children and adolescents with depressive disorders.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with mixed episode

Depressive symptoms in a mixed episode may be qualitatively similar to those of a depressive episode, but in a mixed episode several prominent depressive symptoms occur simultaneously or alternate rapidly with several prominent manic symptoms such as irritability, racing or crowded thoughts, increased talkativeness or increased activity.

Boundary with attention deficit hyperactivity disorder

Problems with attention and concentration in attention deficit hyperactivity disorder are persistent over time (i.e. are not episodic) and are not temporally tied to changes in mood or energy. However, mood disorders and attention deficit hyperactivity disorder can co-occur, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with prolonged grief disorder

Prolonged grief disorder is a persistent and pervasive grief response following the death of a partner, parent, child or other person close to the bereaved that persists for an abnormally long period of time following the loss (e.g. at least 6 months). It is characterized by longing for the deceased or persistent preoccupation with the deceased accompanied by intense emotional pain (e.g. sadness, guilt, anger, denial, blame, difficulty accepting the death, feeling one has lost a part of one's self, inability to experience positive mood, emotional numbness, difficulty in engaging with social or other activities). Some common symptoms of prolonged grief disorder are similar to those observed in a depressive episode (e.g. sadness, loss of interest in activities, social withdrawal, feelings of guilt, suicidal ideation). However, prolonged grief disorder is differentiated from a depressive episode because symptoms are circumscribed and specifically focused on the loss of the loved one, whereas depressive thoughts and emotional reactions typically encompass multiple areas of life. Further, other common symptoms of prolonged grief disorder (e.g. difficulty accepting the loss, difficulty trusting others, feeling bitter or angry about the loss, feeling as though a part of the individual has died) are not characteristic of a depressive episode. The timing of the onset of the symptoms in relation to the loss and whether there is a prior history of a depressive disorder or a bipolar disorder are important to consider in making this distinction.

Boundary with dementia

Older adults experiencing a depressive episode may present with memory difficulties and other cognitive symptoms, which can be severe, and it is important to distinguish these symptoms from dementia. Dementia is an acquired chronic condition characterized by significant cognitive impairment or decline from a previous level of cognitive functioning in two or more cognitive domains (e.g. memory, attention, executive function, language, social cognition, psychomotor speed, visuoperceptual or visuospatial abilities) that is sufficiently severe to interfere with performance or independence in activities of daily living. If memory difficulties and other cognitive symptoms in older adults occur exclusively in the context of a depressive episode, a diagnosis of dementia is generally not appropriate. However, a depressive episode can be superimposed on dementia (e.g. when memory difficulties and other cognitive symptoms substantially predate the onset

of the depressive episode). The timing and rate of onset of the memory difficulties and other cognitive symptoms in relation to other depressive symptoms are important to consider in making this distinction.

Severity and psychotic symptoms specifiers

The severity of all current depressive episodes should be rated based on the number and severity of the symptoms, as well as the impact that the mood disturbance has on the individual's functioning.

In addition, moderate and severe depressive episodes are described as "without psychotic symptoms" (i.e. delusions or hallucinations) or "with psychotic symptoms". By definition, mild depressive episodes do not include psychotic symptoms.

Delusions during moderate or severe depressive episodes are commonly persecutory or self-referential (e.g. being pursued by authorities because of imaginary crimes). In addition, delusions of guilt (e.g. falsely blaming oneself for wrongdoing), poverty (e.g. being bankrupt) and impending disaster (perceived to have been brought on by the individual), as well as somatic (e.g. of having contracted some serious disease) or nihilistic delusions (e.g. believing body organs do not exist) are known to occur. Delusions related to experiences of influence, passivity or control (e.g. the experience that thoughts or actions are not generated by oneself, are being placed in one's mind or withdrawn from one's mind by others, or that one's thoughts are being broadcast to others) can also occur, but less commonly than in schizophrenia and schizoaffective disorder. Auditory hallucinations (e.g. derogatory or accusatory voices that berate the patient for supposed weaknesses or sins) are more common than visual (e.g. visions of death or destruction) or olfactory hallucinations (e.g. the smell of rotting flesh).

Psychotic symptoms are often subtle, and the boundary between psychotic symptoms and persistent depressive ruminations or sustained preoccupations is not always clear. Psychotic symptoms may vary in intensity over the course of a depressive episode or even over the course of the day. Psychotic symptoms may be intentionally concealed by individuals experiencing a depressive episode.

Mild depressive episode

- None of the symptoms of a depressive episode should be present to an intense degree.
- The individual is usually distressed by the symptoms, and has some difficulty in continuing to function in one of more domains (personal, family, social, educational, occupational or other important domains).
- There are no delusions or hallucinations during the episode.

Moderate depressive episode without psychotic symptoms

- Several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall.
- The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational or other important domains).
- There are no delusions or hallucinations during the episode.

Moderate depressive episode with psychotic symptoms

- Several symptoms of a depressive episode are present to a marked degree, or a large number of depressive symptoms of lesser severity are present overall.

- The individual typically has considerable difficulty functioning in multiple domains (personal, family, social, educational, occupational or other important domains).
- There are delusions or hallucinations during the episode.

Severe depressive episode without psychotic symptoms

- Many or most symptoms of a depressive episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree.
- The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational or other important domains).
- There are no delusions or hallucinations during the episode.

Severe depressive episode with psychotic symptoms

- Many or most symptoms of a depressive episode are present to a marked degree, or a smaller number of symptoms are present and manifest to an intense degree.
- The individual has serious difficulty continuing to function in most domains (personal, family, social, educational, occupational or other important domains).
- There are delusions or hallucinations during the episode.

Manic episode

Essential (required) features

- Both of the following features occur concurrently and persist for most of the day, nearly every day, during a period of at least 1 week, unless shortened by a treatment intervention.
  - An extreme mood state is observable or reported, characterized by euphoria, irritability or expansiveness that represents a significant change from the individual's typical mood. Individuals commonly exhibit rapid changes among different mood states (i.e. mood lability).
  - Increased activity or a subjective experience of increased energy is present, and represents a significant change from the individual's typical level.

- Several of the following symptoms are present, representing a significant change from the individual's usual behaviour or subjective state:
  - increased talkativeness or pressured speech (a feeling of internal pressure to be more talkative);
  - flight of ideas or experience of rapid or racing thoughts (e.g. thoughts flow rapidly and, in some cases, illogically from one idea to the next; the person reports that their thoughts are rapid or even racing and has difficulty remaining on topic);
  - increased self-esteem or grandiosity (e.g. the individual believes that they can accomplish tasks well beyond their skill level, or that they are about to become famous – in psychotic presentations of mania, this may be manifested in grandiose delusions);
  - decreased need for sleep (e.g. the person reports being able to function with only 2 or 3 hours of sleep), as distinct from insomnia, in which an individual wants to sleep but cannot;

  - distractibility (e.g. the person cannot stay on task, because attention is drawn to irrelevant or minor environmental stimuli, such as being overly distracted by outside noise during a conversation);
  - impulsive reckless behaviour (e.g. the individual impulsively pursues pleasurable activities without regard to their potential for negative consequences, or impulsively makes major decisions in the absence of adequate planning);
  - an increase in sexual drive, sociability or goal-directed activity.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. cocaine, amfetamines), including withdrawal effects.
- The clinical presentation does not fulfil the diagnostic requirements for a mixed episode.
- The mood disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning, requires intensive treatment (e.g. hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations.

Additional clinical features

- Manic episodes may or may not include psychotic symptoms. A wide variety of psychotic symptoms may occur in mania; among the most common are grandiose delusions (e.g. being chosen by God, having special powers or abilities), persecutory delusions and self-referential delusions (e.g. being conspired against because of one's special identity or abilities). Delusions related to experiences of influence, passivity or control (e.g. the experience that thoughts or actions are not generated by oneself, are being placed in one's mind or withdrawn from one's mind by others, or that one's thoughts are being broadcast to others) may also occur. Hallucinations are less frequent, and commonly accompany delusions of persecution or reference. They are usually auditory (e.g. adulatory voices), and less commonly visual (e.g. visions of deities), somatic or tactile.
- Some patients may exhibit symptoms or impairment in functioning that is sufficiently severe to require immediate intervention (e.g. treatment with mood-stabilizing medications). As a result, their symptoms may not meet the full duration requirement of a manic episode. Episodes that meet the full symptom requirements but last for less than 1 week because they are shortened by a treatment intervention should still be considered manic episodes.
- A manic syndrome arising during antidepressant treatment (e.g. medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a manic episode if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of a manic episode are met after the direct physiological effects of the treatment are likely to have receded.

Boundary with normality (threshold)

- Periods of euphoric or irritable mood that are entirely contextually appropriate (e.g. euphoria after winning a lottery) should not be considered as meeting the mood component of the diagnostic requirements for a manic episode.

Developmental presentations

- Manic episodes are rare in childhood and adolescence. It is normal for children to display overexcitement, exuberance or silliness in contexts such as special occasions, celebrations or some types of play. A manic episode should only be considered when these behaviours are episodic and recurrent (or characterized by rapid onset if a first episode), are inappropriate for the context in which they arise, are in excess of what might be expected given the person's age or developmental level, represent a distinct change from previous functioning, and are associated with significant impairment in personal, family, social, educational or other important areas of functioning.
- When a manic episode occurs in children or adolescents, all the characteristic features can be observed. The reports of other informants (e.g. parents) are particularly important in the case of children in evaluating the nature of symptoms and the extent to which they represent a change from previous functioning. The extreme mood state characteristic of a manic episode may manifest as extreme irritability in children and adolescents. Younger children may exhibit excessive or severe tantrums or increased physical aggression (e.g. throwing things or hitting).
- In children and adolescents, increased distractibility may manifest as a decline in academic performance, increased time needed to complete school assignments or an inability to complete assignments.
- Increased self-esteem or grandiosity associated with a manic episode should be differentiated from children's normal tendency to overestimate their abilities and believe that they have special talents. Grandiose beliefs that are held with clear evidence to the contrary or acted on in such a way that they place the child in danger are more suggestive of a manic episode. Examples of manifestations of grandiosity include magical or unrealistic ideas (e.g. thinking they can fly) in younger children or overestimation of abilities or talents based on current functioning (e.g. believing they should coach their high school sports team) in adolescents.
- Specific manifestations of increased goal-directed activities associated with a manic episode may differ across ages. For example, a younger child might build elaborate projects with blocks, while an adolescent might disassemble electronics or appliances.
- As in adults, children and adolescents may engage in impulsive reckless behaviours during a manic episode, but these are likely to present differently in children and adolescents based on behavioural repertoire and access to specific activities. For example, a child may exhibit risky play, disregarding possible injury (e.g. running into a busy street, climbing a tall tree, trying to fly), whereas for adolescents, analogous behaviour may include driving fast, spending excessively or engaging in risky sexual behaviour.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hypomanic episode

The symptoms of manic episodes may be qualitatively similar to those of hypomanic episodes but, unlike in a hypomanic episode, the mood disturbance is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning or to require intensive treatment (e.g. hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations.

Boundary with mixed episode

Manic symptoms in a mixed episode may be qualitatively similar to those of a manic episode, but in a mixed episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness or suicidal ideation.

Boundary with attention deficit hyperactivity disorder

Many features of a manic episode – such as increased activity, rapid speech and over-talkativeness, distractibility and impulsivity – can be observed in individuals with attention deficit hyperactivity disorder. Differentiating between these disorders can be particularly challenging among children and adolescents. However, in attention deficit hyperactivity disorder, symptoms have their onset before the age of 12 years, are persistent over time (i.e. are not episodic), and are not temporally tied to changes in mood or energy (e.g. are not accompanied by intense mood elevation). However, rates of attention deficit hyperactivity disorder are substantially elevated compared to the general population among children and adolescents diagnosed with bipolar disorders, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Mixed episode

Essential (required) features

- Several prominent manic and several prominent depressive symptoms consistent with those observed in manic episodes and depressive episodes are present, which either occur simultaneously or alternate very rapidly (from day to day or within the same day). Symptoms must include an altered mood state consistent with a manic and/or depressive episode (i.e. depressed, dysphoric, euphoric or expansive mood), and be present most of the day, nearly every day, during a period of at least 2 weeks, unless shortened by a treatment intervention.
- When manic symptoms predominate in a mixed episode, common depressive (contrapolar) symptoms are dysphoric mood, expressed beliefs of worthlessness, hopelessness and suicidal ideation.
- When depressive symptoms predominate in a mixed episode, common manic (contrapolar) symptoms are irritability, racing or crowded thoughts, increased talkativeness and increased activity.

- When depressive and manic symptoms alternate rapidly during a mixed episode, such fluctuations may be observed in mood (e.g. between euphoria and sadness or dysphoria), emotional reactivity (e.g. between flat affect and intense or exaggerated reactiveness to emotional stimuli), drive (e.g. alternating periods of increased and decreased activity, verbal expression, sexual desire or appetite) and cognitive functioning (e.g. periods of activation and inhibition or slowing of thoughts, attention and memory).
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from cocaine).
- The mood disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning, or is accompanied by delusions or hallucinations.

Additional clinical features

- Delusions and hallucinations characteristic of both depressive and manic episodes (see above) can occur in mixed episodes.
- A mixed syndrome arising during antidepressant treatment (e.g. medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a mixed episode if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of a mixed episode are met after the direct physiological effects of the treatment are likely to have receded.

Developmental presentations

- Research regarding mixed episodes in children and adolescents is limited; however, some evidence suggests that adolescents with bipolar disorders may be more likely than adults with bipolar disorders to experience mixed episodes.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with manic episode

Manic symptoms in a mixed episode may be qualitatively similar to those of a manic episode, but in a mixed episode several prominent manic symptoms occur simultaneously or alternate rapidly with several depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness or suicidal ideation.

Boundary with depressive episode

Depressive symptoms in a mixed episode may be qualitatively similar to those of a depressive episode, but in a mixed episode several prominent depressive symptoms occur simultaneously or alternate rapidly with several prominent manic symptoms such as irritability, racing or crowded thoughts, increased talkativeness or increased activity.

Boundary with hypomanic episode

Manic symptoms in a mixed episode may be qualitatively similar to those of a hypomanic episode but, unlike in a hypomanic episode, the mood disturbance in a mixed episode is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning or to require intensive treatment (e.g. hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations. Moreover, in a mixed episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness or suicidal ideation, which are not characteristic of a hypomanic episode.

Hypomanic episode

Essential (required) features

- Both of the following symptoms occur concurrently and persist for most of the day, nearly every day, for at least several days.
  - Persistent elevation of mood or increased irritability is observable or reported, and represents a significant change from the individual's usual range of moods (e.g. the change would be apparent to people who know the individual well). This does not include periods of elevated or irritable mood that are contextually appropriate (e.g. elevated mood after graduating from school or related to falling in love). Rapid shifts among different mood states commonly occur (i.e. mood lability).
  - Increased activity or a subjective experience of increased energy is present, and represents a significant change from the individual's typical level.

- In addition, several of the following symptoms are present, representing a significant change from the individual's usual behaviour (e.g. the change would be apparent to others who know the individual well) or subjective state:
  - increased talkativeness or pressured speech (a feeling of internal pressure to be more talkative);
  - flight of ideas or experience of rapid or racing thoughts (e.g. thoughts flow rapidly from one idea to the next; the person reports that their thoughts are rapid or even racing and has difficulty remaining on a topic);
  - increased self-esteem or grandiosity (e.g. the individual is more self-confident than usual);
  - decreased need for sleep (e.g. the person reports needing less sleep than usual and still feels well-rested), as distinct from insomnia, in which an individual wants to sleep but cannot;
  - distractibility (e.g. the person has difficulty staying on task, because attention is drawn to irrelevant or minor environmental stimuli, such as being overly distracted by outside noise during a conversation);

  - impulsive reckless behaviour (e.g. the individual pursues pleasurable activities with little regard to their potential for negative consequences, or makes decisions in the absence of adequate planning);
  - an increase in sexual drive, sociability or goal-directed activity.

- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. cocaine, amfetamines), including withdrawal effects (e.g. from stimulants).
- The clinical presentation does not fulfil the diagnostic requirements for a mixed episode.
- The mood disturbance is not sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, and is not accompanied by delusions or hallucinations.

Additional clinical features

- A hypomanic syndrome arising during antidepressant treatment (medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) should be considered a hypomanic episode if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of a hypomanic episode are met after the direct physiological effects of the treatment are likely to have receded.

Boundary with normality (threshold)

- Hypomanic episodes are often difficult to distinguish from normal periods of elevated mood – for example, related to positive life events – particularly given that hypomanic episodes are not associated with significant functional impairment. In order to be considered a hypomanic episode, the symptoms must represent a significant and noticeable change from the individual's typical mood and behaviour.
- The occurrence of one or more hypomanic episodes in the absence of a history of other types of mood episodes (manic, depressive or mixed episodes) is not a sufficient basis for a diagnosis of a mood disorder.

Developmental presentations

- As in adults, hypomanic episodes in children and adolescents are similar to – but less severe than – manic episodes, and may present for a shorter period of time. The information in the section on *developmental presentations* for manic episode, above, is therefore also applicable to hypomanic episode.

- Hypomanic episodes may be difficult to distinguish from developmentally normative behaviours in children and adolescents (e.g. changes in sleep or irritability during adolescence). Factors to consider include the episodicity and a marked, co-occurring, change in cognitions (e.g. racing thoughts) or behaviours (e.g. increased activity level).
- Increased irritability in younger children may manifest as excessive or more severe tantrums or increased physical aggression (e.g. throwing things, or hitting).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with manic episode

The symptoms of hypomanic episodes may be qualitatively similar to those of manic episodes, but the mood disturbance is not sufficiently severe to result in marked impairment in personal, family, social, educational, occupational or other important areas of functioning, or to require intensive treatment (e.g. hospitalization) to prevent harm to self or others, and is not accompanied by delusions or hallucinations.

Boundary with mixed episode

Manic symptoms in a mixed episode may be qualitatively similar to those of a hypomanic episode but, unlike in a hypomanic episode, the mood disturbance in a mixed episode is sufficiently severe to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning or to require intensive treatment (e.g. hospitalization) to prevent harm to self or others, or is accompanied by delusions or hallucinations. Moreover, in a mixed episode several prominent manic symptoms occur simultaneously or alternate rapidly with several prominent depressive symptoms such as dysphoric mood, expressed beliefs of worthlessness, hopelessness or suicidal ideation, which are not characteristic of a hypomanic episode.

Boundary with attention deficit hyperactivity disorder

Many features of a hypomanic episode – such as increased activity, rapid speech and over-talkativeness, distractibility and impulsivity – can be observed in individuals with attention deficit hyperactivity disorder. Differentiating between these disorders can be particularly challenging among children and adolescents. However, in attention deficit hyperactivity disorder, symptoms have their onset before the age of 12 years, are persistent over time (i.e. are not episodic), and are not temporally tied to changes in mood or energy (e.g. are not accompanied by mood elevation). However, rates of attention deficit hyperactivity disorder are substantially elevated compared to the general population among children and adolescents diagnosed with bipolar disorders, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Bipolar and related disorders

Bipolar and related disorders are episodic mood disorders defined by the occurrence of manic, mixed or hypomanic episodes or symptoms. These typically alternate over the course of these disorders with depressive episodes or periods of depressive symptoms.

Because the symptoms of bipolar type I and bipolar type II disorders are substantially similar apart from the occurrence of manic or mixed episodes in bipolar type I disorder and hypomanic episodes in bipolar type II disorder, following a separate listing of the essential features for each of these disorders, the other CDDR sections (e.g. additional clinical features, boundaries with other disorders and conditions) are provided for both disorders together.

6A60 Bipolar type I disorder

Essential (required) features

- A history of at least one manic or mixed episode (see above essential features for mood episodes) is required for diagnosis. Although a single manic or mixed episode is sufficient for a diagnosis of bipolar type I disorder, the typical course of the disorder is characterized by recurrent depressive and manic or mixed episodes. Although some episodes may be hypomanic, there must be a history of at least one manic or mixed episode.

Type of current mood episode, severity and psychotic symptoms in current depressive episodes, and remission specifiers

The type of current mood episode, the severity and presence or absence of psychotic symptoms in current depressive episodes, and the degree of remission should be described in bipolar type I disorder. (See descriptions of psychotic symptoms and depressive episode severity in mood episodes on p. 216.) Available categories are:

6A60.0	Bipolar type I disorder, current episode manic, without psychotic symptoms
6A60.1	Bipolar type I disorder, current episode manic, with psychotic symptoms
6A60.2	Bipolar type I disorder, current episode hypomanic
6A60.3	Bipolar type I disorder, current episode depressive, mild
6A60.4	Bipolar type I disorder, current episode depressive, moderate, without psychotic symptoms
6A60.5	Bipolar type I disorder, current episode depressive, moderate, with psychotic symptoms
6A60.6	Bipolar type I disorder, current episode depressive, severe, without psychotic symptoms

6A60.7 Bipolar type I disorder, current episode depressive, severe, with psychotic symptoms
6A60.8 Bipolar type I disorder, current episode depressive, unspecified severity
6A60.9 Bipolar type I disorder, current episode mixed, without psychotic symptoms
6A60.A Bipolar type I disorder, current episode mixed, with psychotic symptoms
6A60.B Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic
6A60.C Bipolar type I disorder, currently in partial remission, most recent episode depressive
6A60.D Bipolar type I disorder, currently in partial remission, most recent episode mixed
6A60.E Bipolar type I disorder, currently in partial remission, most recent episode unspecified
6A60.F Bipolar type I disorder, currently in full remission
6A60.Y Other specified bipolar type I disorder
6A60.Z Bipolar type I disorder, unspecified.

6A60.0 Bipolar type I disorder, current episode manic, without psychotic symptoms

- All diagnostic requirements for a manic episode (see p. 217) are currently met.
- There are no delusions or hallucinations during the current manic episode.

Note: if the individual has experienced manic or mixed episodes in the past, a duration of 1 week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.1 Bipolar type I disorder, current episode manic, with psychotic symptoms

- All diagnostic requirements for a manic episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current manic episode.

Note: if the individual has experienced manic or mixed episodes in the past, a duration of 1 week is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.2 Bipolar type I disorder, current episode hypomanic

- All diagnostic requirements for a hypomanic episode (see p. 222) are currently met.

6A60.3 Bipolar type I disorder, current episode depressive, mild

- All diagnostic requirements for a mild depressive episode (see p. 216) are currently met.

6A60.4 Bipolar type I disorder, current episode depressive, moderate, without psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 216) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A60.5 Bipolar type I disorder, current episode depressive, moderate, with psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A60.6 Bipolar type I disorder, current episode depressive, severe, without psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A60.7 Bipolar type I disorder, current episode depressive, severe, with psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A60.8 Bipolar type I disorder, current episode depressive, unspecified severity

- All diagnostic requirements for a depressive episode (see p. 217) are currently met.
- There is insufficient information to determine the severity of the current depressive episode.

6A60.9 Bipolar type I disorder, current episode mixed, without psychotic symptoms

- All diagnostic requirements for a mixed episode (see p. 220) are currently met.
- There are no delusions or hallucinations during the current mixed episode.

Note: if the individual has experienced manic or mixed episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.A Bipolar type I disorder, current episode mixed, with psychotic symptoms

- All diagnostic requirements for a mixed episode (see p. 220) are currently met.
- There are delusions or hallucinations during the current mixed episode.

Note: if the individual has experienced manic or mixed episodes in the past, a duration of 2 weeks is not required in order to diagnose a current episode if all other diagnostic requirements are met.

6A60.B Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic

- The most recent mood episode was a manic or hypomanic episode (see p. 217).
- The full diagnostic requirements for a manic or hypomanic episode are no longer met, but some significant manic or hypomanic symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type I disorder.

6A60.C Bipolar type I disorder, currently in partial remission, most recent episode depressive

- The most recent mood episode was a depressive episode (see p. 212).
- The full diagnostic requirements for a depressive episode are no longer met, but some significant depressive symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type I disorder.

6A60.D Bipolar type I disorder, currently in partial remission, most recent episode mixed

- The most recent mood episode was a mixed episode (see p. 220).
- The full diagnostic requirements for a mixed episode are no longer met, but some significant mood symptoms remain.

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type I disorder.

6A60.E Bipolar type I disorder, currently in partial remission, most recent episode unspecified

- The full diagnostic requirements for a mood episode are no longer met, but some significant mood symptoms remain.
- There is insufficient information to determine the nature of the most recent mood episode.

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type I disorder.

6A60.F Bipolar type I disorder, currently in full remission

- There are currently no longer any significant mood symptoms.

6A60.Y Other specified bipolar type I disorder

6A60.Z Bipolar type I disorder, unspecified

Course features for bipolar type I disorder

- Although the onset of a first manic, hypomanic or depressive episode most often occurs during the late teen years, onset of bipolar type I disorder can occur at any time through the life-cycle, including in older adulthood. Late-onset mood symptoms may be more likely to be caused by the effects of medications or substances or other medical conditions.
- The majority of individuals who experience a single manic episode will go on to develop recurrent mood episodes. More than half of manic episodes will be immediately followed by a depressive episode.
- The risk of recurrence of mood episodes in bipolar type I disorder increases with the number of prior mood episodes.
- Individuals with bipolar type I disorder are at increased lifetime risk of suicidality.

Sex- and/or gender-related features for bipolar type I disorder

- Prevalence rates for bipolar type I disorder are similar between men and women, with a tendency for men to exhibit earlier onset of symptoms.
- Manic episodes occur more commonly in men, and are typically more severe and impairing. In contrast, women are more likely to experience depressive episodes, mixed episodes and rapid cycling.
- Disorders due to substance use often co-occur with bipolar type I disorder among men, whereas women are more likely to experience comorbid medical conditions including migraines, obesity and thyroid disease, as well as co-occurring mental disorders including anxiety and fear-related disorders and eating disorders.
- An additional diagnosis of 6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms or 6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms may be assigned to indicate that the current episode is perinatal.

6A61 Bipolar type II disorder

Essential (required) features

- A history of at least one hypomanic episode *and* at least one depressive episode (see above essential features for mood episodes) is required for diagnosis. The typical course of the disorder is characterized by recurrent depressive and hypomanic episodes.
- There is no history of manic or mixed episodes.

Type of current mood episode, severity and psychotic symptoms in current depressive episodes, and remission specifiers

The type of current mood episode, the severity and presence or absence of psychotic symptoms in current depressive episodes, and the degree of remission should be described in bipolar type II disorder. (See descriptions of psychotic symptoms and depressive episode severity in mood episodes on p. 216.) Available categories are:

6A61.0	Bipolar type II disorder, current episode hypomanic
6A61.1	Bipolar type II disorder, current episode depressive, mild
6A61.2	Bipolar type II disorder, current episode depressive, moderate, without psychotic symptoms

6A61.3 Bipolar type II disorder, current episode depressive, moderate, with psychotic symptoms
6A61.4 Bipolar type II disorder, current episode depressive, severe, without psychotic symptoms
6A61.5 Bipolar type II disorder, current episode depressive, severe, with psychotic symptoms
6A61.6 Bipolar type II disorder, current episode depressive, unspecified severity
6A61.7 Bipolar type II disorder, currently in partial remission, most recent episode hypomanic
6A61.8 Bipolar type II disorder, currently in partial remission, most recent episode depressive
6A61.9 Bipolar type II disorder, currently in partial remission, most recent episode unspecified
6A61.A Bipolar type II disorder, currently in full remission
6A61.Y Other specified bipolar type II disorder
6A61.Z Bipolar type II disorder, unspecified.

6A61.0 Bipolar type II disorder, current episode hypomanic

- All diagnostic requirements for a hypomanic episode (see p. 222) are currently met.

6A61.1 Bipolar type II disorder, current episode depressive, mild

- All diagnostic requirements for a mild depressive episode (see p. 216) are currently met.

6A61.2 Bipolar type II disorder, current episode depressive, moderate, without psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 216) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A61.3 Bipolar type II disorder, current episode depressive, moderate, with psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A61.4 Bipolar type II disorder, current episode depressive, severe, without psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A61.5 Bipolar type II disorder, current episode depressive, severe, with psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A61.6 Bipolar type II disorder, current episode depressive, unspecified severity

- All diagnostic requirements for a depressive episode (see p. 212) are currently met.
- There is insufficient information to determine the severity of the current depressive episode.

6A61.7 Bipolar type II disorder, currently in partial remission, most recent episode hypomanic

- The most recent mood episode was a hypomanic episode (see p. 222).
- The full diagnostic requirements for a hypomanic episode are no longer met, but some significant hypomanic symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type II disorder.

6A61.9 Bipolar type II disorder, currently in partial remission, most recent episode depressive

- The most recent mood episode was a depressive episode (see p. 212).
- The full diagnostic requirements for a depressive episode are no longer met, but some significant depressive symptoms remain. (Note that in some cases, residual mood symptoms may be of opposite polarity to the symptoms of the most recent episode.)

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type II disorder.

6A61.A Bipolar type II disorder, currently in partial remission, most recent episode unspecified

- The full diagnostic requirements for a mood episode are no longer met, but some significant mood symptoms remain.

- There is insufficient information to determine the nature of the most recent mood episode.

Note: this category may also be used to designate the re-emergence of subthreshold mood symptoms following an asymptomatic period in a person who has previously met the diagnostic requirements for bipolar type II disorder.

6A61.Y Bipolar type II disorder, currently in full remission

- There are currently no longer any significant mood symptoms.

6A61.Z Other specified bipolar type II disorder

6A61.8 Bipolar type II disorder, unspecified

Course features for bipolar type II disorder

- Bipolar type II disorder has its onset most often during the mid-20s; however, onset during late adolescence and throughout early and mid-adulthood may also occur. Initial onset of bipolar type II disorder in older adults is rare.
- While onset typically begins following a single depressive episode, some individuals experience several depressive episodes before occurrence of a hypomanic episode.
- The presence of chronic and gradually worsening experiences of affective lability or mood swings, particularly during adolescence and early adulthood, has been associated with an increased risk of developing bipolar type II disorder.
- Up to 15% of individuals with bipolar type II disorder will subsequently develop a manic episode, resulting in a change of diagnosis to bipolar type I disorder.
- Spontaneous intra-episode shifts from a depressive episode to a hypomanic episode are not uncommon.
- Risk of recurrence increases with each subsequent mood episode.

Sex- and/or gender-related features for bipolar type II disorder

- Women are more likely to experience hypomanic episodes, mixed episodes and rapid cycling. The time of greatest risk of a hypomanic episode is during the early postpartum period following childbirth. Approximately half of those who experience postpartum hypomanic symptoms will later develop a depressive disorder. Differentiating between normal experiences of mood and sleep disturbances typically associated with caring for a

newborn and symptoms of bipolar type II disorder is challenging. An additional diagnosis of 6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms may be assigned to indicate that the current episode is perinatal.

Symptomatic and course presentation specifiers for mood episodes in bipolar type I and bipolar type II disorders

Additional specifiers may be applied to describe a current mood episode in the context of bipolar type I disorder (depressive, manic, mixed or hypomanic episodes) and bipolar type II disorder (depressive or hypomanic episodes). These specifiers indicate other important features of the clinical presentation or of the course, onset and pattern of mood episodes. These specifiers are not mutually exclusive, and as many may be added as apply. (Note that these same specifiers may also be applied to current depressive episodes in the context of depressive disorders, with the exception of rapid cycling, which is specific to bipolar type I and bipolar type II disorders.)

Available specifiers are as follows:

6A80.0 with prominent anxiety symptoms

- This specifier can be applied if, in the context of a current depressive, manic, mixed or hypomanic episode, prominent and clinically significant anxiety symptoms (e.g. feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, autonomic symptoms) have been present for most of the time during the episode. If there have been panic attacks during the current depressive or mixed episode, these should be recorded separately (see the *with panic attacks* specifier). When the diagnostic requirements for both a mood episode and an anxiety or fear-related disorder are met, the anxiety or fear-related disorder should also be diagnosed.

6A80.1 with panic attacks

- This specifier can be applied if, in the context of a current episode, there have been panic attacks during the past month that occur specifically in response to depressive ruminations or other anxiety-provoking cognitions. If panic attacks occur exclusively in response to such thoughts, the *with panic attacks* specifier should be applied rather than an additional co-occurring diagnosis of panic disorder. If some panic attacks over the course of the depressive or mixed episode have been unexpected and not exclusively in response to depressive or anxiety-provoking thoughts, and the full diagnostic requirements for panic disorder are met, a separate diagnosis of panic disorder should be assigned.

6A80.2 current depressive episode persistent

- This specifier can be applied if the diagnostic requirements for a depressive episode are currently met and have been met continuously (five or more characteristic symptoms occurring most of the day, nearly every day) for at least the past 2 years.

6A80.3 current depressive episode with melancholia

- This specifier can be applied if, in the context of a current depressive episode, several of the following symptoms have been present during the worst period of the current episode:
  - loss of interest or pleasure in most activities that are normally enjoyable to the individual (i.e. pervasive anhedonia);
  - lack of emotional reactivity to normally pleasurable stimuli or circumstances (i.e. mood does not lift even transiently with exposure);
  - terminal insomnia (i.e. waking in the morning 2 hours or more before the usual time);
  - depressive symptoms that are worse in the morning;
  - marked psychomotor retardation or agitation;
  - marked loss of appetite or loss of weight.

6A80.4 with seasonal pattern of mood episode onset

- This specifier can be applied to bipolar type I or bipolar type II disorder if there has been a regular seasonal pattern of onset and remission of at least one type of episode (i.e. depressive, manic, mixed or hypomanic episodes). The other types of mood episodes may not follow this pattern.
- A substantial majority of the relevant mood episodes should correspond with the seasonal pattern.
- A seasonal pattern should be differentiated from an episode that is coincidental with a particular season but predominantly related to a psychological stressor that regularly occurs at that time of the year (e.g. seasonal unemployment).

6A80.5 with rapid cycling

- This specifier can be applied if the bipolar type I or bipolar type II disorder is characterized by a high frequency of mood episodes (at least four) over the past 12 months. There may be a switch from one polarity of mood to the other, or the mood episodes may be demarcated by a period of remission.
- In individuals with a high frequency of mood episodes, some may have a shorter duration than those usually observed in bipolar type I or bipolar type II disorder. In particular, depressive periods may only last several days. However, if depressive and manic symptoms alternate very rapidly (i.e. from day to day or within the same day), a mixed episode should be diagnosed rather than rapid cycling.

In the context of bipolar type I or bipolar type II disorder, mood episodes that occur during pregnancy or commence within about 6 weeks after delivery (the puerperium) can be identified using one of the following two additional diagnostic codes, depending on whether delusions, hallucinations or other psychotic symptoms are present. These diagnoses should be assigned in addition to the relevant bipolar disorder diagnosis.

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms

- This additional diagnostic code should be used for mood episodes that arise during pregnancy or commence within about 6 weeks after delivery, and that do not include delusions, hallucinations or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called "postpartum blues" or "baby blues"). (See p. 640 for complete diagnostic requirements.)

6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms

- This additional diagnostic code should be used for mood episodes that arise during pregnancy or commence within about 6 weeks after delivery, and that include delusions, hallucinations or other psychotic symptoms. (See p. 642 for complete diagnostic requirements.)

Note: for the following sections, see also material under depressive episode (p. 212), manic episode (p. 217), mixed episode (p. 220) and hypomanic episode (p. 222). Material on additional clinical features, boundary with normality (threshold), developmental presentations and boundaries with other disorders and conditions (differential diagnosis) that relates specifically to the mood episodes is contained in those sections, whereas material focusing on bipolar type I and bipolar type II disorders overall appears below.

Additional clinical features for bipolar type I and bipolar type II disorders

- In combination with a history of one or more depressive episodes, a mixed, manic or hypomanic episode arising during antidepressant treatment (e.g. medication, electroconvulsive therapy, light therapy, transcranial magnetic stimulation) is grounds for a diagnosis of bipolar type I or bipolar type II disorder if the syndrome persists after the treatment is discontinued and the full diagnostic requirements of the mood episode are met after the direct physiological effects of the treatment are likely to have receded.
- Inter-episode periods may be characterized by complete remission of symptoms or by the presence of residual hypomanic, manic, mixed or depressive symptoms, in which case the *partial remission* specifier should be applied.
- Suicide risk is significantly higher among individuals diagnosed with bipolar type I and bipolar type II disorders than among the general population, particularly during depressive or mixed episodes and among individuals with rapid cycling.

- Recurrent panic attacks in bipolar type I and bipolar type II disorders may be indicative of greater severity, poorer response to treatment and greater risk of suicide.
- Family history is an important factor to consider because heritability of bipolar disorders is the highest of all mental disorders.
- When individuals with bipolar type II disorder seek clinical services, they almost invariably do so during depressive episodes. Given that individuals experiencing a hypomanic episode often have a subjective experience of improved functioning (e.g. greater productivity and creativity at work), they rarely seek clinical care during such episodes. Thus, hypomanic episodes usually must be assessed retrospectively in individuals presenting with depressive symptoms.
- Individuals initially diagnosed with bipolar type II disorder are at high risk of experiencing a manic or mixed episode during their lifetime. If this occurs, the diagnosis should be changed to bipolar type I disorder.
- Patients diagnosed with bipolar type I and bipolar type II disorders are at elevated risk of developing a variety of medical conditions affecting the cardiovascular system (e.g. hypertension) and metabolism (e.g. hyperglycaemia), some of which may be due to the effects of the chronic use of medications used to treat bipolar disorders.
- Individuals with bipolar type I or bipolar type II disorder exhibit high rates of co-occurring mental, behavioural and neurodevelopmental disorders, most commonly anxiety and fear-related disorders and disorders due to substance use.

Boundary with normality (threshold) for bipolar type I and bipolar type II disorders

- The presence or history of hypomanic episodes in the absence of a history of at least one depressive episode is not a sufficient basis for a presumptive diagnosis of bipolar type II disorder.

Culture-related features for bipolar type I and bipolar type II disorders

- Studies indicate that the prevalence of bipolar and related disorders varies across cultural, ethnic and migrant groups, partly as a function of social stress. Symptom expression may also vary and be shaped by common cultural idioms, cultural histories or personal histories that are prominent in identity formation and expressed as grandiose ideas or beliefs. For example, grandiosity may be expressed in culturally specific ways such that a Muslim individual experiencing a manic episode may believe they are Muhammad, whereas a Christian individual may believe they are Jesus. Individuals from the person's cultural group may be helpful in distinguishing normative expressions of belief or ritual from manic or psychotic experiences and behaviours.
- In some cultural contexts, mood changes are more readily expressed in the form of bodily symptoms (e.g. pain, fatigue, weakness) rather than directly reported as psychological symptoms.
- The perceived abnormality or acceptability of depressive symptoms may vary across cultures, affecting symptom detection and treatment acceptability. For example, some social groups or age cohorts may consider depressive symptoms to be normal reactions to adversity, depending on their tolerance of negative emotions or social withdrawal.

- Some types of symptoms may be considered more shameful or severe according to cultural norms, leading to reporting biases. For example, some cultures may emphasize shame more than guilt, whereas in others suicidal behaviour and thinking may be prohibited or highly stigmatized. In some cultural groups, features such as sadness and lack of productivity may be perceived as signs of personal weakness and therefore be underreported.
- The cultural salience of depressive symptoms may vary across social groups as a result of varying cultural "scripts" for the disorder, which make specific types of symptoms more prominent. For example, psychological (e.g. sadness, emotional numbness, rumination), moral (e.g. guilt, worthlessness), social/interpersonal (e.g. lack of productivity, conflictive relationships), hedonic (e.g. decreased pleasure), spiritual (e.g. dreams of dead relatives) or somatic (e.g. insomnia, pain, fatigue, dizziness) symptoms may systematically predominate among specific cultural or social groups.
- Symptoms attributed to cultural concepts of distress may be evoked when asking about depressive symptomatology. Among Chinese people, for example, symptoms of *shenjing shuairuo*, or weakness of the nervous system (e.g. weakness, headache, bodily aches, fatigue, feeling vexed, loss of face) may be commonly reported. Culturally related symptoms and idioms of distress may complicate detection of depressive disorders and assessment of severity, including whether psychotic symptoms are present. Examples include pain in heart, soul loss, aching heart, complaints related to "nerves" and heat inside the body. In some cultures, a focus on a particular observable behaviour (e.g. "thinking too much") may be what is reported.

Boundaries with other disorders and conditions (differential diagnosis) for bipolar type I and bipolar type II disorders

Boundary with cyclothymic disorder

In cyclothymic disorder, the number, severity and/or duration of depressive symptoms have never met the threshold required for a depressive episode, and there is no evidence of a history of mixed or manic episodes.

Boundary with attention deficit hyperactivity disorder

Although a manic, hypomanic or mixed episode may include symptoms characteristic of attention deficit hyperactivity disorder – such as distractibility, hyperactivity and impulsivity – bipolar type I and bipolar type II disorders are differentiated from attention deficit hyperactivity disorder by their episodic nature and the accompanying elevated, euphoric or irritable mood. However, attention deficit hyperactivity disorder and bipolar type I and bipolar type II disorders can co-occur. When they do, attention deficit hyperactivity disorder symptoms tend to worsen during hypomanic, manic or mixed episodes.

Boundary with schizophrenia and other primary psychotic disorders

Individuals with both bipolar type I and bipolar type II disorders can exhibit psychotic symptoms during depressive episodes, and individuals with bipolar type I disorder can exhibit psychotic symptoms during manic or mixed episodes, but these symptoms occur only during mood episodes. Conversely, individuals with a diagnosis of schizophrenia and other primary psychotic disorders may experience significant depressive or manic mood symptoms during psychotic episodes. In such cases, if the symptoms do not meet the diagnostic requirements for a depressive, manic or mixed episode, their presence and severity in the context of a psychotic disorder diagnosis can be denoted by applying specifier scales from symptomatic manifestations of primary psychotic

disorders – i.e. the *depressive mood symptoms* specifier in primary psychotic disorders (see p. 195) or the *manic mood symptoms* specifier in primary psychotic disorders (see p. 196). If all diagnostic requirements for both a depressive, manic or mixed episode and schizophrenia are met concurrently or within a few days of each other, and other diagnostic requirements are met, the diagnosis of schizoaffective disorder should be assigned rather than bipolar type I or bipolar type II disorder. A hypomanic episode superimposed on schizophrenia does not qualify for a diagnosis of schizoaffective disorder. However, a diagnosis of bipolar type I or bipolar type II disorder can co-occur with a diagnosis of schizophrenia or another primary psychotic disorder, and both diagnoses may be assigned if the full diagnostic requirements for each are met and psychotic symptoms are present outside of mood episodes.

Boundary with anxiety and fear-related disorders

Symptoms of anxiety, including panic attacks, are common in bipolar type I and bipolar type II disorders, and in some individuals may be a prominent aspect of the clinical presentation. In such cases, the *with prominent anxiety symptoms* specifier should be applied to the diagnosis for non-panic anxiety systems. If the anxiety symptoms meet the diagnostic requirements for an anxiety or fear-related disorder, the appropriate diagnosis from the anxiety or fear-related disorders grouping should also be assigned. For panic attacks, if these occur entirely in the context of anxiety associated with depressive, hypomanic, manic or mixed episodes in bipolar type I and bipolar type II disorders, they are appropriately designated using the *with panic attacks* specifier. However, if panic attacks also occur outside of symptomatic mood episodes, and other diagnostic requirements are met, a separate diagnosis of panic disorder should be considered. Both specifiers may be assigned if warranted.

Boundary with personality disorder

Individuals with a personality disorder may exhibit impulsivity or mood instability, but personality disorder does not include depressive, hypomanic, manic or mixed episodes. However, co-occurrence of personality disorder and bipolar type I and bipolar type II disorders is relatively common. Symptoms of personality disorder should be assessed outside the context of a mood episode to avoid conflating symptoms of a mood episode with personality traits, but both diagnoses may be assigned if the diagnostic requirements for each are met.

Boundary with oppositional defiant disorder

It is common, particularly among children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of a mood disorder. For example, noncompliance may be a result of depressive symptoms (e.g. diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). During hypomanic or manic episodes, individuals are less likely to follow rules and comply with directions. Oppositional defiant disorder often co-occurs with mood disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of hypomanic, manic, depressive or mixed episodes, a separate diagnosis of oppositional defiant disorder should not be assigned. However, both diagnoses may be assigned if the full diagnostic requirements for each are met, and the behaviour problems associated with oppositional defiant disorder are observed outside the occurrence of a mood episode. The oppositional defiant disorder *with chronic irritability-anger* specifier may be used if appropriate.

Boundary with substance-induced mood disorder

A depressive, hypomanic, manic or mixed syndrome due to the effects of a substance or medication other than antidepressant medication on the central nervous system (e.g. cocaine, amfetamines) – including withdrawal effects – should be diagnosed as a substance-induced mood disorder rather than bipolar type I or bipolar type II disorder. The presence of continuing mood disturbance should be assessed once the physiological effects of the relevant substance subside.

Boundary with other mental disorders

Irritability is a symptom that is also observed in other disorders (e.g. depressive disorders, generalized anxiety disorder). In order to attribute this symptom to a manic, hypomanic or mixed episode, the clinician should establish the episodicity of the symptom and its co-occurrence with other symptoms consistent with a manic, hypomanic or mixed episode.

Boundary with secondary mood syndrome

A depressive, hypomanic, manic or mixed syndrome that is a manifestation of another medical condition should be diagnosed as secondary mood syndrome rather than bipolar type I or bipolar type II disorder.

6A62 Cyclothymic disorder

Essential (required) features

- Mood instability over an extended period of time (i.e. 2 years or more) characterized by numerous hypomanic and depressive periods is required for diagnosis. (In children and adolescents depressed mood can manifest as pervasive irritability.) Hypomanic periods may or may not have been sufficiently severe or prolonged to meet the diagnostic requirements for a hypomanic episode.
- Mood symptoms are present for more days than not. While brief symptom-free intervals are consistent with the diagnosis, there have never been any prolonged symptom-free periods (e.g. lasting 2 months or more) since the onset of the disorder.
- There is no history of manic or mixed episodes.
- During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a depressive episode.
- The symptoms are not a manifestation of another medical condition (e.g. hyperthyroidism), and are not due to the effects of a substance or medication on the central nervous system (e.g. stimulants), including withdrawal effects.
- The symptoms result in significant distress about experiencing persistent mood instability or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- In children, it may be appropriate to assign the diagnosis of cyclothymic disorder after a somewhat briefer period of initial symptoms (e.g. 1 year).

- Individuals initially diagnosed with cyclothymic disorder are at high risk of developing bipolar type I or bipolar type II disorder during their lifetime.
- Individuals with cyclothymic disorder do not typically exhibit psychotic symptoms.

Boundary with normality (threshold)

- Cyclothymic disorder is distinguished from normal variations in mood by a history of distress or difficulty functioning due to repeated occurrences of mood disturbance.

Course features

- The course of cyclothymic disorder is often gradual and persistent. Onset of cyclothymic disorder commonly occurs during adolescence or early adulthood, and may be difficult to differentiate from normal mood instability associated with hormonal changes that accompany puberty.

Developmental presentations

- Onset of cyclothymic disorder in children typically occurs before the age of 10 years. Symptoms of irritability (particularly during periods of low mood) and sleep disturbance are often the prominent clinical features and reasons for consultation.
- Cyclothymic disorder is underdiagnosed in children and adolescents despite evidence for greater prevalence of this disorder in this age group compared to bipolar type I and bipolar type II disorders. However, the most common trajectory in children and adolescents is symptom remission; only a minority will maintain the diagnosis into adulthood or be at high risk of developing bipolar type I or bipolar type II disorder.
- Co-occurrence of other mental, behavioural and neurodevelopmental disorders is common among children and adolescents with cyclothymic disorder – particularly attention deficit hyperactivity disorder.

Culture-related features

- Little information is available about cultural influences on cyclothymic disorder. The information on culture-related features for bipolar type I and bipolar type II disorders (p. 237) may be relevant.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with single episode depressive disorder and recurrent depressive disorder

During the first 2 years of the disorder, depressive periods in cyclothymic disorder should not be sufficient to meet the diagnostic requirements for a depressive episode. Outside this 2-year period, there may be instances in which the symptoms are severe enough to constitute a depressive episode. In such cases, if there is no history of hypomanic episodes, single episode depressive disorder or recurrent depressive disorder may be diagnosed along with cyclothymic disorder.

Boundary with bipolar type I disorder

If the number and severity of symptoms reaches the diagnostic threshold for a manic episode or a mixed episode in the context of an ongoing cyclothymic disorder, the diagnosis should be changed to bipolar type I disorder.

Boundary with bipolar type II disorder

If the number and severity of symptoms reaches the diagnostic threshold for single episode depressive disorder or recurrent depressive disorder in the context of an ongoing cyclothymic disorder, and the individual has a history of hypomanic episodes but no history of manic or mixed episodes, the diagnosis should be changed to bipolar type II disorder.

Boundary with attention deficit hyperactivity disorder

Although hypomanic symptoms overlap with symptoms of attention deficit hyperactivity disorder – such as distractibility, hyperactivity and impulsivity – hypomanic episodes are differentiated from attention deficit hyperactivity disorder by their episodic nature and the accompanying elevated, euphoric or irritable mood. Attention deficit hyperactivity disorder and cyclothymic disorder can co-occur; when this occurs, attention deficit hyperactivity disorder symptoms tend to worsen during hypomanic episodes.

Boundary with oppositional defiant disorder

It is common, particularly among children and adolescents, for patterns of noncompliance and symptoms of irritability/anger to arise as part of a mood disorder. For example, noncompliance may be a result of depressive symptoms (e.g. diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). Individuals may be less likely to follow rules and comply with directions when experiencing hypomanic symptoms. In contrast, individuals with oppositional defiant disorder do not exhibit the episodicity characteristic of cyclothymic disorder. However, oppositional defiant disorder often co-occurs with mood

disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of mood disturbance, a separate diagnosis of oppositional defiant disorder should not be assigned. However, both diagnoses may be assigned if the full diagnostic requirements for each are met, and the behaviour problems associated with oppositional defiant disorder are observed outside of periods of mood disturbance. The oppositional defiant disorder *with chronic irritability-anger* specifier may be used if appropriate.

Boundary with personality disorder

Individuals with personality disorder may exhibit impulsivity or mood instability, but cyclothymic disorder does not include persistent problems in self-functioning and interpersonal dysfunction that characterize personality disorder. Personality disorder should be assessed outside the context of a mood episode to avoid conflating symptoms of a mood episode with personality traits, but both diagnoses may be assigned if the diagnostic requirements for each are fulfilled.

Boundary with secondary mood syndrome

Chronic mood instability that is a manifestation of another medical condition should be diagnosed as secondary mood syndrome rather than cyclothymic disorder.

Boundary with substance-induced mood disorder

Chronic mood instability due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants), should be diagnosed as substance-induced mood disorder rather than cyclothymic disorder.

6A6Y Other specified bipolar or related disorder

Essential (required) features

- The presentation is characterized by manic or hypomanic symptoms (with or without depressive symptoms) that share primary clinical features with other bipolar and related disorders (e.g. persistent elevation of mood).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the bipolar and related disorders grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. schizoaffective disorder, a disorder due to addictive behaviours, a personality disorder).
- The symptoms and behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication (e.g. alcohol, cocaine) on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6A6Z Bipolar or related disorder, unspecified

Depressive disorders

Depressive disorders are characterized by depressive mood (e.g. feeling sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural or neurovegetative symptoms that significantly affect the individual's ability to function. A depressive disorder should not be diagnosed in individuals who have ever experienced a manic, mixed or hypomanic episode, which would indicate the presence of a bipolar disorder.

Because the presentation of single episode depressive disorder is the same as that of recurrent depressive disorder apart from a history of prior depressive episodes, following a separate listing of the essential features for each of these disorders, the other CDDR sections (e.g. additional clinical features, boundaries with other disorders and conditions) are provided for both disorders together.

6A70 Single episode depressive disorder

Essential (required) features

- The presence or a history of a single depressive episode (see above essential features) is required for diagnosis.
- There is no history of manic, mixed or hypomanic episodes, which would indicate the presence of a bipolar disorder.

Severity, psychotic symptoms and remission specifiers

The depressive episode in single episode depressive disorder should be classified according to the severity of the episode or the degree of remission. Moderate and severe episodes should also be classified according to the presence or absence of psychotic symptoms. (See the descriptions of episode severity and psychotic symptoms in depressive episodes on p. 216.) Available categories are:

6A70.0	Single episode depressive disorder, mild
6A70.1	Single episode depressive disorder, moderate, without psychotic symptoms
6A70.2	Single episode depressive disorder, moderate, with psychotic symptoms
6A70.3	Single episode depressive disorder, severe, without psychotic symptoms
6A70.4	Single episode depressive disorder, severe, with psychotic symptoms
6A70.5	Single episode depressive disorder, unspecified severity
6A70.6	Single episode depressive disorder, currently in partial remission
6A70.7	Single episode depressive disorder, currently in full remission
6A70.Y	Other specified single episode depressive disorder
6A70.Z	Single episode depressive disorder, unspecified.

6A70.0 Single episode depressive disorder, mild

- All diagnostic requirements for a mild depressive episode (see p. 216) are currently met.

6A70.1 Single episode depressive disorder, moderate, without psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 216) are currently met.
- There are no delusions or hallucinations during the depressive episode.

6A70.2 Single episode depressive disorder, moderate, with psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the depressive episode.

6A70.3 Single episode depressive disorder, severe, without psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are no delusions or hallucinations during the depressive episode.

6A70.4 Single episode depressive disorder, severe, with psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the depressive episode.

6A70.5 Single episode depressive disorder, unspecified severity

- All diagnostic requirements for a depressive episode (see p. 212) are currently met.
- There is insufficient information to determine the severity of the depressive episode.

6A70.6 Single episode depressive disorder, currently in partial remission

- The full diagnostic requirements for a depressive episode (see p. 212) are no longer met, but some significant depressive symptoms remain.

Note: this category may also be used to designate the re-emergence of subthreshold depressive symptoms following an asymptomatic period.

6A70.7 Single episode depressive disorder, currently in full remission

- There are currently no longer any significant depressive symptoms.

6A70.Y Other specified single episode depressive disorder

6A70.Z Single episode depressive disorder, unspecified

6A71 Recurrent depressive disorder

Essential (required) features

- A history of at least two depressive episodes (see above essential features), which may include a current episode, separated by several months without significant mood disturbance is required for diagnosis.
- There is no history of manic, mixed or hypomanic episodes, which would indicate the presence of a bipolar disorder.

Note: if depressive episodes are superimposed on dysthymic disorder, the requirement for several months without significant mood disturbance between episodes would be satisfied by a return to the chronic dysthymic symptom picture that preceded the episode.

Severity, psychotic symptoms and remission specifiers

The current depressive episode in the context of recurrent depressive disorder should be classified according to the severity of the current episode or the degree of remission. Moderate and severe current episodes should also be classified according to the presence or absence of psychotic symptoms. (See the descriptions of episode severity and psychotic symptoms in depressive episodes on p. 216.) Available categories are:

6A71.0	Recurrent depressive disorder, current episode mild
6A71.1	Recurrent depressive disorder, current episode moderate, without psychotic symptoms
6A71.2	Recurrent depressive disorder, current episode moderate, with psychotic symptoms
6A71.3	Recurrent depressive disorder, current episode severe, without psychotic symptoms
6A71.4	Recurrent depressive disorder, current episode severe, with psychotic symptoms
6A71.5	Recurrent depressive disorder, current episode, unspecified severity
6A71.6	Recurrent depressive disorder, currently in partial remission
6A71.7	Recurrent depressive disorder, currently in full remission
6A71.Y	Other specified recurrent depressive disorder
6A71.Z	Recurrent depressive disorder, unspecified.

6A71.0 Recurrent depressive disorder, current episode mild

- All diagnostic requirements for a mild depressive episode (see p. 216) are currently met.

6A71.1 Recurrent depressive disorder, current episode moderate, without psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 216) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A71.2 Recurrent depressive disorder, current episode moderate, with psychotic symptoms

- All diagnostic requirements for a moderate depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A71.3 Recurrent depressive disorder, current episode severe, without psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are no delusions or hallucinations during the current depressive episode.

6A71.4 Recurrent depressive disorder, current episode severe, with psychotic symptoms

- All diagnostic requirements for a severe depressive episode (see p. 217) are currently met.
- There are delusions or hallucinations during the current depressive episode.

6A71.5 Recurrent depressive disorder, current episode, unspecified severity

- All diagnostic requirements for a depressive episode (see p. 212) are currently met.
- There is insufficient information to determine the severity of the current depressive episode.

6A71.6 Recurrent depressive disorder, currently in partial remission

- The full diagnostic requirements for a depressive episode (see p. 212) are no longer met, but some significant depressive symptoms remain.

Note: this category may also be used to designate the re-emergence of subthreshold depressive symptoms following an asymptomatic period.

6A71.7 Recurrent depressive disorder, currently in full remission

- There are currently no longer any significant depressive symptoms.

6A71.Y Other specified recurrent depressive disorder

6A71.Z Recurrent depressive disorder, unspecified

Symptomatic and course presentations for mood episodes in single episode and recurrent depressive disorders

Additional specifiers may be applied to describe the presentation and characteristics of a current depressive episode in the context of single episode depressive disorder or recurrent depressive disorder. These specifiers indicate other important features of the clinical presentation or of the course, onset and pattern of depressive episodes. These specifiers are not mutually exclusive, and as many may be added as apply. (Note that these same specifiers may also be applied to current depressive episodes in the context of bipolar type I or bipolar type II disorder.)

Available specifiers are as follows:

6A80.0 with prominent anxiety symptoms

- This specifier can be applied if, in the context of a current depressive episode, prominent and clinically significant anxiety symptoms (e.g. feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension, autonomic symptoms) have been present for most of the time during the episode. If there have been panic attacks during the current depressive episode, these should be recorded separately (see the *with panic attacks* specifier). When the diagnostic requirements for both a depressive episode and an anxiety or fear-related disorder are met, the anxiety or fear-related disorder diagnosis should also be diagnosed.

6A80.1 with panic attacks

- This specifier can be applied if, in the context of a current depressive episode, there have been panic attacks during the past month that occur specifically in response to depressive ruminations or other anxiety-provoking cognitions. If panic attacks occur exclusively in response to such thoughts, the *with panic attacks* specifier should be applied rather than an additional co-occurring diagnosis of panic disorder. If some panic attacks over the course of the depressive episode have been unexpected and not exclusively in response to depressive thoughts, a separate diagnosis of panic disorder should be assigned.

6A80.2 current depressive episode persistent

- This specifier can be applied if the diagnostic requirements for a depressive episode are currently met and have been met continuously (five or more characteristic symptoms occurring most of the day, nearly every day) for at least the past 2 years.

6A80.3 current depressive episode with melancholia

- This specifier can be applied if, in the context of a current depressive episode, several of the following symptoms have been present during the worst period of the current episode:
  - loss of interest or pleasure in most activities that are normally enjoyable to the individual (i.e. pervasive anhedonia);
  - lack of emotional reactivity to normally pleasurable stimuli or circumstances (i.e. mood does not lift even transiently with exposure);
  - terminal insomnia, i.e. waking in the morning 2 hours or more before the usual time;
  - depressive symptoms that are worse in the morning;
  - marked psychomotor retardation or agitation;
  - marked loss of appetite or loss of weight.

6A80.4 with seasonal pattern of mood episode onset

- This specifier can be applied to recurrent depressive disorder if there has been a regular seasonal pattern of onset and remission of depressive episodes.
- A substantial majority of depressive episodes should correspond with the seasonal pattern.
- A seasonal pattern should be differentiated from an episode that is coincidental with a particular season but predominantly related to a psychological stressor that regularly occurs at that time of the year (e.g. seasonal unemployment).

In the context of single episode depressive disorder or recurrent depressive disorder, depressive episodes that occur during pregnancy or commence within about 6 weeks after delivery (the puerperium) can be identified using one of the following two additional diagnostic codes, depending on whether delusions, hallucinations or other psychotic symptoms are present. These diagnoses should be assigned in addition to the relevant depressive disorder diagnosis.

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms

- This additional diagnostic code should be used for mood episodes that arise during pregnancy or commence within about 6 weeks after delivery, and that do not include delusions, hallucinations or other psychotic symptoms. This designation should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called "postpartum blues" or "baby blues"). (See p. 640 for complete diagnostic requirements.)

6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms

- This additional diagnostic code should be used for mood episodes that arise during pregnancy or commence within about 6 weeks after delivery, and that include delusions, hallucinations or other psychotic symptoms. (See p. 642 for complete diagnostic requirements.)

Note: for the following sections, see also material under depressive episode (p. 212), manic episode (p. 217), mixed episode (p. 220) and hypomanic episode (p. 222). Material on additional clinical features, boundary with normality (threshold), developmental presentations and boundaries with other disorders and conditions (differential diagnosis) that relates specifically to the mood episodes is contained in those sections, whereas material focusing on single episode depressive disorder and recurrent depressive disorder overall appears below.

Additional clinical features for single episode depressive disorder and recurrent depressive disorder

- Suicide risk is significantly higher among individuals diagnosed with single episode depressive disorder or recurrent depressive disorder than among the general population.
- Recurrent panic attacks in single episode depressive disorder or recurrent depressive disorder may be indicative of greater severity, poorer response to treatment, and greater risk of suicide.
- The presence of dementia or a disorder of intellectual development does not rule out the diagnosis of single episode depressive disorder or recurrent depressive disorder, but communication difficulties may make it necessary to rely more than usual on observations made by clinicians or knowledgeable collateral informants to make the diagnosis. Observable symptoms include psychomotor retardation, loss of appetite and weight, and sleep disturbance.
- There is a greater risk of single episode depressive disorder or recurrent depressive disorder among individuals with a family history of single episode depressive disorder or recurrent depressive disorder.

- Co-occurrence with other mental, behavioural and neurodevelopmental disorders is common, including anxiety and fear-related disorders, bodily distress disorder, obsessive-compulsive and related disorders, oppositional defiant disorder, disorders due to substance use, eating disorders and personality disorder.

Course features for single episode depressive disorder and recurrent depressive disorder

- The prevalence of depressive disorders significantly increases at puberty, with the average age of onset occurring during the mid-20s.
- In the absence of intervention, depressive episodes typically last 3–4 months, with nearly half of affected individuals experiencing symptom reduction within 3 months and the majority experiencing remission within 1 year. Remission and recurrence rates vary widely; most individuals experience an average of four depressive episodes over their lifetime, and approximately half experience a recurrence within the first 5 years. The risk of relapse increases with each subsequent depressive episode.
- It is common for depressive symptoms to persist between discrete episodes (i.e. partial remission), with some individuals never experiencing a complete remission of symptoms. This presentation warrants closer attention, because symptom persistence has been associated with shorter time to relapse as well as co-occurrence of other mental, behavioural and neurodevelopmental disorders including personality disorder, anxiety and fear-related disorders, and disorders due to substance use.
- Lower rates of recovery are associated with longer duration and severity of symptoms and the presence of psychotic features.
- Individuals with bipolar disorders often present initially with a depressive episode. Vulnerability factors associated with transition from a depressive disorder to a bipolar disorder include earlier age at onset, a family history of bipolar disorders and the presence of psychotic symptoms.

Culture-related features for single episode depressive disorder and recurrent depressive disorder

- The cultural salience of depressive symptoms may vary across social groups as a result of varying cultural "scripts" for the disorder, which make specific types of symptoms more prominent. For example, psychological (e.g. sadness, emotional numbness, rumination), moral (e.g. guilt, worthlessness), social/interpersonal (e.g. lack of productivity, conflictive relationships), hedonic (e.g. decreased pleasure), spiritual (e.g. dreams of dead relatives) or somatic (e.g. insomnia, pain, fatigue, dizziness) symptoms may systematically predominate among specific cultural or social groups.
- In some cultural contexts, mood changes are more readily expressed in the form of bodily symptoms (e.g. pain, fatigue, weakness) rather than directly reported as psychological symptoms.
- The perceived abnormality or acceptability of depressive symptoms may vary across cultures, affecting symptom detection and treatment acceptability. For example, some social groups or age cohorts may consider depressive symptoms to be normal reactions to adversity, depending on their tolerance of negative emotions or social withdrawal.

- Some types of symptoms may be considered more shameful or severe according to cultural norms, leading to reporting biases. For example, some cultural groups may emphasize shame more than guilt, whereas in others suicidal behaviour and thinking may be prohibited or highly stigmatized. In some cultural groups, features such as sadness and lack of productivity may be perceived as signs of personal weakness and therefore be underreported.
- Symptoms attributed to cultural concepts of distress may be evoked when asking about depressive symptomatology. Among Chinese people, for example, symptoms of shenjing shuairuo, or weakness of the nervous system (e.g. weakness, headache, bodily aches, fatigue, feeling vexed, loss of face) may be commonly reported. Culturally related symptoms and idioms of distress may complicate detection of depressive disorders and assessment of severity, including whether psychotic symptoms are present. Examples include pain in heart, soul loss, aching heart, complaints related to "nerves" and heat inside the body. In some cultures, a focus on a particular observable behaviour (e.g. "thinking too much") may be what is reported.

Sex- and/or gender-related features for single episode depressive disorder and recurrent depressive disorder

- Lifetime prevalence of depressive disorders is approximately twice as high among women. Gender differences in prevalence coincide with onset of puberty.
- Although women are more likely to attempt suicide, men are more likely to die by suicide by virtue of using more lethal methods.
- Women with a diagnosis of a depressive disorder are more likely to experience co-occurring anxiety and fear-related disorders, disturbances in appetite and weight gain, whereas it is more common for men to experience co-occurring alcohol and other disorders due to substance use, poor impulse control and increased risk-taking behaviour.

Boundaries with other disorders and conditions (differential diagnosis) for single episode depressive disorder and recurrent depressive disorder

Boundary with dysthymic disorder

Single episode depressive disorder and recurrent depressive disorder are differentiated from dysthymic disorder by the number of symptoms and the course of the disorder. Dysthymic disorder is a chronic and persistent condition, and during the initial period of 2 years necessary to establish the diagnosis, the number and duration of symptoms are not sufficient to meet the diagnostic requirements for a diagnosis of single episode depressive disorder or recurrent depressive disorder. After this initial period, if the number and severity of symptoms reaches the diagnostic threshold for a depressive episode in the context of an ongoing dysthymic disorder, both dysthymic disorder and either single episode depressive disorder or recurrent depressive disorder may be diagnosed. Unlike dysthymic disorder, recurrent depressive disorder is episodic in nature. However, long periods of subthreshold depressive symptoms that occur following depressive episodes when there has not been an initial 2-year period of subthreshold symptoms are better diagnosed as single episode depressive disorder in partial remission or recurrent depressive disorder in partial remission.

Boundary with mixed depressive and anxiety disorder

Individuals who present with both depressive and anxiety symptoms more days than not for a period of 2 weeks or more, with neither set of symptoms – considered separately – being sufficiently severe, numerous or lasting to justify a diagnosis of single episode depressive disorder or recurrent depressive disorder or an anxiety or fear-related disorder may be diagnosed with mixed depressive and anxiety disorder.

Boundary with cyclothymic disorder

Although, in general, depressive periods in cyclothymic disorder are not sufficient to meet the diagnostic requirements for a depressive episode, there may be instances in which the symptoms are severe enough to constitute a depressive episode. In such cases, if there is no history of hypomanic episodes, single episode depressive disorder or recurrent depressive disorder may be diagnosed, as appropriate, along with cyclothymic disorder.

Boundary with schizophrenia and other primary psychotic disorders

Individuals with single episode depressive disorder or recurrent depressive disorder can exhibit psychotic symptoms, but these occur only during depressive episodes. Conversely, individuals with a diagnosis of schizophrenia and other primary psychotic disorders may experience significant depressive symptoms during psychotic episodes. In such cases, if the depressive symptoms do not meet the diagnostic requirements for a depressive episode, the *depressive mood symptoms* specifier may be applied to the psychotic disorder diagnosis. If all diagnostic requirements for both a depressive episode and schizophrenia are met concurrently or within a few days of each other, the diagnosis of schizoaffective disorder should be assigned rather than single episode depressive disorder or recurrent depressive disorder. However, a diagnosis of single episode depressive disorder or recurrent depressive disorder can co-occur with a diagnosis of schizophrenia or another primary psychotic disorder, and both diagnoses may be assigned if the full diagnostic requirements for each are met, and psychotic symptoms are present outside of depressive episodes.

Boundary with generalized anxiety disorder

Generalized anxiety disorder and depressive episodes in single episode depressive disorder or recurrent depressive disorder can share several features, such as somatic symptoms of anxiety, difficulty with concentration, sleep disruption and feelings of dread associated with pessimistic thoughts. Single episode depressive disorder or recurrent depressive disorder are differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities and other characteristic symptoms of a depressive episode (e.g. appetite changes, feelings of worthlessness, recurrent thoughts of death). In generalized anxiety disorder, individuals are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g. family, finances, work) rather than thoughts of worthlessness or hopelessness. Rumination often occurs in the context of single episode depressive disorder or recurrent depressive disorder but, unlike in generalized anxiety disorder, is not usually accompanied by persistent worry and apprehension about various everyday aspects of life. Generalized anxiety disorder may co-occur with single episode depressive disorder or recurrent depressive disorder, but should only be diagnosed if the diagnostic requirements for generalized anxiety disorder were met prior to the onset of or following complete remission of a depressive episode.

Boundary with other anxiety and fear-related disorders

Symptoms of anxiety, including panic attacks, are common in single episode depressive disorder and recurrent depressive disorder, and in some individuals may be a prominent aspect of the clinical presentation. In such cases, the *with prominent anxiety symptoms* specifier should be applied to the diagnosis for non-panic anxiety symptoms. If the anxiety symptoms meet the diagnostic requirements for an anxiety or fear-related disorder, the appropriate diagnosis from the anxiety and fear-related disorders grouping should also be assigned. For panic attacks, if these

occur entirely in the context of anxiety associated with depressive episodes in single episode depressive disorder or recurrent depressive disorder, they are appropriately designated using the *with panic attacks* specifier. However, if panic attacks also occur outside of symptomatic mood episodes and other diagnostic requirements are met, a separate diagnosis of panic disorder should be considered. Both specifiers may be assigned if warranted.

Boundary with adjustment disorder

Adjustment disorder is characterized by a maladaptive reaction to identifiable psychosocial stressors, and can include depressive symptoms (e.g. rumination), but does not include a sufficient number and severity of symptoms to meet the requirements for a depressive episode. If the adjustment reaction meets the diagnostic requirements for single episode depressive disorder or recurrent depressive disorder, even in the presence of identifiable psychosocial stressors, single episode depressive disorder or recurrent depressive disorder should be diagnosed rather than adjustment disorder.

Boundary with oppositional defiant disorder

It is common – particularly in children and adolescents – for patterns of noncompliance and symptoms of irritability/anger to arise as part of a mood disorder. Specifically, noncompliance may result from a number of depressive symptoms (e.g. diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). Oppositional defiant disorder often co-occurs with mood disorders, and irritability/anger can be a common symptom across these disorders. When the behaviour problems occur primarily in the context of a depressive episode, a separate diagnosis of oppositional defiant disorder should not be assigned. However, both diagnoses may be assigned if the full diagnostic requirements for each are met, and the behaviour problems associated with oppositional defiant disorder are observed outside the occurrence of depressive episodes.

Boundary with insomnia

Individuals experiencing insomnia may also report depressed mood and may develop other depressive symptoms. However, the breadth and severity of symptoms are generally not sufficient to meet the diagnostic requirements for single episode depressive disorder or recurrent depressive disorder.

Boundary with secondary mood syndrome

A depressive syndrome that is a manifestation of another medical condition (e.g. hypothyroidism) should be diagnosed as secondary mood syndrome rather than single episode depressive disorder or recurrent depressive disorder.

Boundary with substance-induced mood disorder

A depressive syndrome due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants), should be diagnosed as substance-induced mood disorder rather than single episode depressive disorder or recurrent depressive disorder. The presence of continuing mood disturbance should be assessed once the physiological effects of the relevant substance subside.

6A72 Dysthymic disorder

Essential (required) features

- Persistent depressed mood (i.e. lasting 2 years or more), for most of the day, for more days than not, as reported by the individual (e.g. feeling down, sad) or as observed (e.g. tearful, defeated appearance), is required for diagnosis. In children and adolescents depressed mood can manifest as pervasive irritability.
- The depressed mood is accompanied by additional symptoms typically seen in a depressive episode, though these may be milder in form. Examples include:
  - markedly diminished interest or pleasure in activities
  - reduced concentration and attention, or indecisiveness
  - low self-worth, or excessive or inappropriate guilt
  - hopelessness about the future
  - disturbed sleep or increased sleep
  - diminished or increased appetite
  - low energy or fatigue.
- During the first 2 years of the disorder, there has never been a 2-week period during which the number and duration of symptoms were sufficient to meet the diagnostic requirements for a depressive episode.
- While brief symptom-free intervals during the period of persistent depressed mood are consistent with the diagnosis, there have never been any prolonged symptom-free periods (e.g. lasting 2 months or more) since the onset of the disorder.
- There is no history of manic, mixed or hypomanic episodes, which would indicate the presence of a bipolar or related disorder.
- The symptoms are not a manifestation of another medical condition (e.g. hypothyroidism), and are not due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants).
- The symptoms result in significant distress about experiencing persistent depressive symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- In children, it may be appropriate to assign the diagnosis of dysthymic disorder after a briefer period of initial symptoms (e.g. 1 year).
- Suicide risk is significantly higher among individuals diagnosed with dysthymic disorder than among the general population.

- There is a greater risk of dysthymic disorder among individuals with a family history of mood disorders.
- Co-occurrence with other mental disorders is common, including anxiety and fear-related disorders, bodily distress disorder, obsessive-compulsive and related disorders, oppositional defiant disorder, disorders due to substance use, feeding and eating disorders, and personality disorder.

Boundary with normality (threshold)

- Some depressed mood is a normal reaction to severe adverse life events and problems, and is common in the community. Dysthymic disorder is differentiated from this common experience by the severity, range and duration of symptoms. Assessment of the presence or absence of signs or symptoms should be made relative to typical functioning of the individual.

Course features

- Dysthymic disorder typically has a gradual onset beginning in childhood, adolescence or early adulthood.
- The course of dysthymic disorder may fluctuate between dysthymia and symptoms of single episode depressive disorder or recurrent depressive disorder.
- Early onset of dysthymic disorder is associated with increased likelihood of co-occurring anxiety and fear-related disorders, personality disorder and substance use disorders.
- In contrast to high rates of co-occurring mental, behavioural and neurodevelopmental disorders in young adults, dysthymic disorder in older adults typically occurs without co-occurrence.
- Greater symptom severity, higher levels of negative affectivity, poorer global functioning and the presence of an anxiety or fear-related disorder or conduct-dissocial disorder have been associated with poorer long-term outcomes.

Developmental presentations

- In young children, dysthymic disorder may present as somatic complaints (e.g. headaches, stomach pains), whining, increased anxiety or fearfulness, or excessive crying.
- Adolescents with dysthymic disorder may demonstrate low self-esteem, and may be more reactive to negative (or perceived negative) feedback from others.
- Children and adolescents may present with pervasive irritability rather than depressed mood. However, the presence of irritability is not in and of itself indicative of dysthymic disorder, and may indicate the presence of another mental, behavioural or neurodevelopmental disorder or be a normal reaction to frustration.

- In children and adolescents, reduced ability to concentrate or sustain attention may manifest as a decline in academic performance, increased time needed to complete school assignments, or an inability to complete assignments.

Culture-related features

- Little information is available about cultural influences on dysthymic disorder. The information on culture-related features for single episode depressive disorder and recurrent depressive disorder (p. 251) may be relevant.

Sex- and/or gender-related features

- Although dysthymic disorder is more common among women during early and middle adulthood, there are no notable gender differences among older adults with late-onset dysthymic disorder.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with single episode depressive disorder and recurrent depressive disorder

Dysthymic disorder is differentiated from single episode depressive disorder and recurrent depressive disorder by the number of symptoms and the course of the disorder. Dysthymic disorder is a chronic and persistent condition, and during the initial period of 2 years necessary to establish the diagnosis, the number and duration of symptoms are not sufficient to meet the diagnostic requirements for a diagnosis of single episode depressive disorder or recurrent depressive disorder. After this initial period, if the number and severity of symptoms reaches the diagnostic threshold for a depressive episode in the context of an ongoing dysthymic disorder, both dysthymic disorder and either single episode depressive disorder or recurrent depressive disorder may be diagnosed. Unlike dysthymic disorder, recurrent depressive disorder is episodic in nature. However, long periods of subthreshold depressive symptoms that occur following depressive episodes when there has not been an initial 2-year period of subthreshold symptoms are better diagnosed as single episode depressive disorder in partial remission or recurrent depressive disorder in partial remission.

Boundary with bipolar and related disorders

Individuals with a pattern of depressive symptoms that resembles dysthymic disorder who have a history of manic or mixed episodes should be diagnosed with bipolar type I disorder. A pattern of chronic mood instability that is characterized by periods of both depressive symptomatology, and that is not sufficiently severe or prolonged to meet the diagnostic requirements for a depressive episode and periods of hypomanic symptomatology should be diagnosed as cyclothymic disorder.

Boundary with schizophrenia and other primary psychotic disorders

Depressive symptoms are common in schizophrenia, schizoaffective disorder and other primary psychotic disorders, and these should only be diagnosed as dysthymic disorder if they persist for several years after the full remission of psychotic symptoms.

Boundary with generalized anxiety disorder

Generalized anxiety disorder and dysthymic disorder can share several features, such as somatic symptoms of anxiety, difficulty with concentration, sleep disruption and feelings of dread associated with pessimistic thoughts. Dysthymic disorder is differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities and other characteristic symptoms of dysthymic disorder (e.g. appetite changes, feelings of worthlessness, recurrent thoughts of death). In generalized anxiety disorder, individuals are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g. family, finances, work) rather than thoughts of worthlessness or hopelessness. Rumination often occurs in the context of dysthymic disorder but, unlike in generalized anxiety disorder, is not usually accompanied by persistent worry and apprehension about various everyday aspects of life. Generalized anxiety disorder may co-occur with dysthymic disorder, but should only be diagnosed if the diagnostic requirements for generalized anxiety disorder were met prior to the onset of dysthymic disorder.

Boundary with oppositional defiant disorder

It is common – particularly in children and adolescents – for patterns of noncompliance and symptoms of irritability/anger to arise as part of mood disturbance. Specifically, noncompliance may result from a number of depressive symptoms (e.g. diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). When the behaviour problems occur primarily in the context of mood disturbance, a separate diagnosis of oppositional defiant disorder should not be assigned.

Boundary with secondary mood syndrome

A chronic depressive syndrome that is a manifestation of another medical condition (e.g. hypothyroidism) should be diagnosed as secondary mood syndrome rather than dysthymic disorder.

Boundary with substance-induced mood disorder

A chronic depressive syndrome due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines) – including withdrawal effects (e.g. from stimulants) – should be diagnosed as substance-induced mood disorder rather than dysthymic disorder.

6A73 Mixed depressive and anxiety disorder

Essential (required) features

- The presence of both depressive and anxiety symptoms for most of the time during a period of 2 weeks or more is required for diagnosis.

  - Depressive symptoms include depressed mood or markedly diminished interest or pleasure in activities.
  - There are multiple anxiety symptoms, which may include feeling nervous, anxious or on edge, not being able to control worrying thoughts, fear that something awful will happen, having trouble relaxing, muscle tension or sympathetic autonomic symptoms.
- Neither the depressive nor the anxiety symptoms – considered separately – are sufficiently severe, numerous or lasting to meet the diagnostic requirements of another depressive disorder or an anxiety or fear-related disorder. There is no history of manic or mixed episodes, which would indicate the presence of a bipolar disorder.
- The symptoms are not a manifestation of another medical condition (e.g. hypothyroidism, hyperthyroidism), and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects (e.g. from alcohol, benzodiazepines).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Individuals with this mixture of comparatively mild symptoms of depression and anxiety are frequently seen in primary care, but many more cases exist among the population at large, which never come to clinical attention.

Boundary with normality (threshold)

- If worry is the only anxiety symptom (i.e. no sympathetic autonomic or other anxiety symptoms are present), a diagnosis of mixed depressive and anxiety disorder diagnosis is not appropriate.

Course features

- Epidemiological studies have yielded varying results regarding the course and onset of mixed depressive and anxiety disorder.
- While there is some evidence to suggest that approximately half of individuals with mixed depressive and anxiety disorder will experience remission of symptoms within 1 year of onset, those who do not remit are at increased risk of developing a mental, behavioural or neurodevelopmental disorder that meets the full diagnostic requirements – typically for a depressive disorder or an anxiety or fear-related disorder.

Culture-related features

- Little information is available about cultural influences on mixed depressive and anxiety disorder. The information on culture-related features for single episode depressive disorder and recurrent depressive disorder (p. 251) and for generalized anxiety disorder (p. 258) may be relevant.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with other depressive disorders and anxiety and fear-related disorders

If the depressive symptoms or anxiety symptoms meet the diagnostic requirements for a depressive episode or an anxiety or fear-related disorder, then the depressive or anxiety or fear-related disorder should be diagnosed rather than mixed depressive and anxiety disorder. If appropriate, the *with prominent anxiety symptoms* specifier may be applied to single episode depressive disorder or recurrent depressive disorder diagnoses.

Boundary with bipolar and related disorders

Mixed depressive and anxiety disorder should not be diagnosed if there is a history of manic or mixed episodes, which would indicate the presence of a bipolar disorder.

Boundary with adjustment disorder

If the onset of the symptoms occurs in close association with significant life changes or stressful life events, a diagnosis of adjustment disorder is generally more appropriate than mixed depressive and anxiety disorder.

6A7Y Other specified depressive disorder

Essential (required) features

- The presentation is characterized by depressive symptoms that share primary clinical features with other depressive disorders (e.g. depressed mood, decreased engagement in pleasurable activities, decreased energy levels, disruptions in sleep or eating).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the depressive disorders grouping.

- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. schizophrenia or another primary psychotic disorder, an anxiety or fear-related disorder, a disorder specifically associated with stress).
- The symptoms and behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication (e.g. alcohol, benzodiazepine) on the central nervous system, including withdrawal effects (e.g. from cocaine).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6A7Z Depressive disorder, unspecified

Secondary-parented category in depressive disorders

The following category is classified in Chapter 16 on diseases of the genitourinary system, but is cross-listed (secondary-parented) here because of the prominence of mood symptoms in its clinical presentation, and to assist in differential diagnosis.

GA34.41 Premenstrual dysphoric disorder

Essential (required) features

- During a majority of menstrual cycles within the past year, a pattern of mood, somatic or cognitive symptoms is present that begins several days before the onset of menses, starts to improve within a few days after the onset of menses, and then becomes minimal or absent within approximately 1 week following the onset of menses. The temporal relationship of the symptoms and luteal and menstrual phases of the cycle should ideally be confirmed by a prospective symptom diary over at least two symptomatic menstrual cycles.
- The symptoms include:
  - at least one affective symptom such as mood lability, irritability, depressed mood or anxiety;
  - additional somatic or cognitive symptoms such as lethargy, joint pain, overeating, hypersomnia, breast tenderness, swelling of extremities, concentration difficulties or forgetfulness.
- The symptoms are not better accounted for by another mental disorder (e.g. a mood disorder, an anxiety or fear-related disorder).

- The symptoms are not a manifestation of another medical condition (e.g. endometriosis, polycystic ovary disease, adrenal system disorders or hyperprolactinemia), and are not due to the effects of a substance or medication on the central nervous system (e.g. hormone treatment, alcohol), including withdrawal effects (e.g. from stimulants).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Boundary with normality (threshold)

- Mild mood changes (e.g. increased emotional lability, irritability, subjective tension) that occur during late luteal or menstrual phase of the cycle for many women should not be labelled as premenstrual dysphoric disorder. In contrast to premenstrual dysphoric disorder, these symptoms are less intense and do not typically result in significant distress or impairment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with premenstrual tension syndrome

Many women may experience cyclic emotional, physical or behavioural symptoms that interfere with their lifestyles during the luteal phase of the menstrual cycle that are appropriately diagnosed and treated as premenstrual tension syndrome. This is in contrast to premenstrual dysphoric disorder, in which the symptoms are considerably more severe and cause significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Boundary with other mental, behavioural and neurodevelopmental disorders, including mood disorders that are exacerbated premenstrually

Mood symptoms characteristic of premenstrual dysphoric disorder – including depressed mood, irritability and anxiety – can be present in other mental, behavioural and neurodevelopmental disorders (e.g. depressive disorders, bipolar disorders, generalized anxiety disorder). Although symptoms of these disorders may be exacerbated during the late luteal and menstrual phases, premenstrual dysphoric disorder is differentiated by the absence of symptoms 1 week following the onset of menses. Because of the difficulty in accurate recall of the relationship between menstrual cycle and the course of symptoms, prospective mood ratings for two consecutive cycles should be considered.

Boundary with dysmenorrhoea

Dysmenorrhoea is characterized by cyclic pelvic pain or lower, umbilical or suprapubic abdominal pain preceding or accompanying menstruation that interferes with daily activities. Unlike premenstrual dysphoric disorder, the onset of dysmenorrhoea is coincident with the start of rather than prior to menses. Furthermore, mood symptoms are not typically associated with this condition.

Boundary with the effects of hormones and their synthetic substitutes and antagonists

Use of hormone treatments, including for contraceptive purposes, may result in unwanted side-effects that include mood, somatic and cognitive symptoms. If symptoms do not persist after cessation of these medications beyond the period when their physiological effects should have subsided, a diagnosis of premenstrual dysphoric disorder should not be assigned.

6A8Y Other specified mood disorder

Essential (required) features

The presentation is characterized by mood symptoms that cannot clearly be described as bipolar or depressive in nature (e.g. marked and persistent irritability in the absence of other clear manic or depressive symptoms).

- The symptoms do not fulfil the diagnostic requirements for any other disorder in the mood disorders grouping.
- The symptoms are not better accounted for by anothewr mental, behavioural or neurodevelopmental disorder (e.g. schizophrenia or another primary psychotic disorder, an anxiety or fear-related disorder, a disorder specifically associated with stress, oppositional defiant disorder with chronic irritability-anger, personality disorder).
- The symptoms and behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication (e.g. alcohol, benzodiazepine) on the central nervous system, including withdrawal effects (e.g. from cocaine).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6A8Z Mood disorder, unspecified

Anxiety and fear-related disorders

Anxiety and fear-related disorders are characterized by excessive fear and anxiety, and related behavioural disturbances, with symptoms severe enough to result in significant distress or impairment in functioning. Fear and anxiety are closely related phenomena: fear represents a reaction to perceived imminent threat in the present, whereas anxiety is more future-oriented, referring to perceived anticipated threat. One of the major ways in which different anxiety and fear-related disorders are distinguished from one another is the focus of apprehension – that is, the stimuli or situations that trigger the fear or anxiety. The focus of apprehension may be highly specific, as in specific phobia, or relate to a broader class of situations, as in generalized anxiety disorder. The clinical presentation of anxiety and fear-related disorders typically includes specific associated cognitions that can assist in differentiating among the disorders by clarifying the focus of apprehension.

Anxiety and fear-related disorders include the following:

6B00	Generalized anxiety disorder
6B01	Panic disorder
6B02	Agoraphonia
6B03	Specific phobia
6B04	Social anxiety disorder
6B05	Separation anxiety disorder
6B06	Selective mutism
6B0Y	Other specified anxiety or fear-related disorder
6B0Z	Anxiety or fear-related disorder, unspecified.

General cultural considerations for anxiety and fear-related disorders

- For many cultural groups, somatic complaints rather than cognitive symptoms may predominate in the clinical presentation.
- In some cultural contexts, symptoms of fear and anxiety may be described primarily in terms of external forces or factors (e.g. witchcraft, sorcery, malign magic or envy), and not as an internal experience or psychological state.

6B00 Generalized anxiety disorder

Essential (required) features

- Marked symptoms of anxiety are required for diagnosis, manifested in either:
  - general apprehensiveness that is not restricted to any particular environmental circumstance (i.e. "free-floating anxiety"); or
  - excessive worry (apprehensive expectation) about negative events occurring in several different aspects of everyday life (e.g. work, finances, health, family).
- Anxiety and general apprehensiveness or worry are accompanied by additional characteristic symptoms, such as:
  - muscle tension or motor restlessness;
  - sympathetic autonomic overactivity as evidenced by frequent gastrointestinal symptoms such as nausea and/or abdominal distress, heart palpitations, sweating, trembling, shaking and/or dry mouth;
  - subjective experience of nervousness, restlessness or being "on edge";
  - difficulty concentrating;
  - irritability;
  - sleep disturbances (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- The symptoms are not transient and persist for at least several months, for more days than not.
- The symptoms are not better accounted for by another mental disorder (e.g. a depressive disorder).
- The symptoms are not a manifestation of another medical condition (e.g. hyperthyroidism), and are not due to the effects of a substance or medication on the central nervous system (e.g. caffeine, cocaine), including withdrawal effects (e.g. alcohol, benzodiazepines).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Some individuals with generalized anxiety disorder may only report general apprehensiveness accompanied by chronic somatic symptoms without being able to articulate specific worry content.
- Behavioural changes such as avoidance, frequent need for reassurance (especially in children) and procrastination may be seen. These behaviours typically represent an effort to reduce apprehension or prevent untoward events from occurring.

Boundary with normality (threshold)

- Anxiety and worry are normal emotional/cognitive states that commonly occur when people are under stress. At optimal levels, anxiety and worry may help to direct problem-solving efforts, focus attention adaptively and increase alertness. Normal anxiety and worry are usually sufficiently self-regulated that they do not interfere with functioning or cause marked distress. In generalized anxiety disorder, the anxiety or worry is excessive, persistent and intense, and may have a significant negative impact on functioning. Individuals under extremely stressful circumstances (e.g. living in a war zone) may experience intense and impairing anxiety and worry that is appropriate to their environmental circumstances. These experiences should not be regarded as symptomatic of generalized anxiety disorder if they occur only under such circumstances.

Course features

- Onset of generalized anxiety disorder may occur at any age. However, the typical age of onset is during the early to mid-30s.
- Earlier onset of symptoms is associated with greater impairment of functioning and presence of co-occurring mental disorders.
- Severity of generalized anxiety disorder symptoms often fluctuates between threshold and subthreshold forms of the disorder, and full remission of symptoms is uncommon.
- Although the clinical features of generalized anxiety disorder generally remain consistent across the lifespan, the content of the individual's worry may vary over time, and there are differences in worry content among different age groups. Children and adolescents tend to worry about the quality of academic and sports-related performance, whereas adults tend to worry more about their own well-being or that of their loved ones.

Developmental presentations

- Anxiety and fear-related disorders are the most prevalent mental disorders of childhood and adolescence. Among these disorders, generalized anxiety disorder is one of the most common in late childhood and adolescence.
- Occurrence of generalized anxiety disorder increases across late childhood and adolescence with development of cognitive abilities that support the capacity for worry, which is a core feature of the disorder. As a result of their less developed cognitive abilities, generalized anxiety disorder is uncommon in children younger than 5 years.
- While the essential features of generalized anxiety disorder still apply to children and adolescents, specific manifestations of worry in children may include being overly concerned and compliant with rules, as well as a strong desire to please others. Affected children may become upset when they perceive peers as acting out or being disobedient. Consequently, children and adolescents with generalized anxiety disorder may be more likely to report excessively on their peers' misbehaviour or to act as an authority figure around peers, condemning misbehaviour. This may have a negative effect on affected individuals' interpersonal relationships.
- Children and adolescents with generalized anxiety disorder may engage in excessive reassurance-seeking from others, asking questions repeatedly, and may exhibit distress when faced with uncertainty. They may be overly perfectionistic, taking additional time to complete tasks such as homework or classwork. Sensitivity to perceived criticism is common.
- When generalized anxiety disorder does occur in children, somatic symptoms – particularly those related to sympathetic autonomic overactivity – may be prominent aspects of the clinical presentation. Common somatic symptoms in children with generalized anxiety disorder include frequent headaches, abdominal pain and gastrointestinal distress. As with adults, children and adolescents also experience sleep disturbances, including delayed sleep onset and night-time wakefulness.
- The number and content of worries typically manifests differently across childhood and adolescence. Younger children are more like to have more concerns about their safety, their health or the health of others. Adolescents typically report a greater number of worries, with content shifting to performance, perfectionism and whether they will be able to meet the expectations of others.
- Adolescents with generalized anxiety disorder may demonstrate excessive irritability and have an increased risk of co-occurring depressive symptoms.

Culture-related features

- For many cultural groups, somatic complaints rather than excessive worry may predominate in the clinical presentation. These symptoms may involve a range of physical complaints not typically associated with generalized anxiety disorder, such as dizziness and heat in the head.

- Realistic worries may be misjudged as excessive without appropriate contextual information. For example, migrant workers may worry greatly about being deported, but this may be related to actual deportation threats by their employer. On the other hand, evidence of worries across several different aspects of everyday life may be difficult to establish when an individual places emphasis on a single overwhelming source of worry (e.g. financial concerns).
- Worry content may vary by cultural group, related to topics that are salient in the milieu. For example, in societies where relationships with deceased relatives are important, worry may focus on their spiritual status in the afterlife. Worry in more individualistic cultures may emphasize personal achievement, fulfilment of expectations or self-confidence.

Sex- and/or gender-related features

- Lifetime prevalence of generalized anxiety disorder is approximately twice as high among women.
- Among individuals with onset of generalized anxiety disorder during childhood or adolescence, girls are likely to have earlier symptom onset.
- Although symptom presentation does not vary by gender – including the common co-occurrence of generalized anxiety disorder and depressive disorders – men are more likely to experience co-occurring disorders due to substance use.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with panic disorder

Panic disorder is characterized by recurrent, unexpected, self-limited episodes of intense fear or anxiety. Generalized anxiety disorder is differentiated by a more persistent and less circumscribed chronic feeling of apprehensiveness, usually associated with worry about a variety of different everyday life events. Individuals with generalized anxiety disorder may experience panic attacks that are triggered by specific worries. If an individual with generalized anxiety disorder experiences panic attacks exclusively in the context of the worry about a variety of everyday life events, or general apprehensiveness without the presence of unexpected panic attacks, an additional diagnosis of panic disorder is not warranted and the presence of panic attacks may be indicated using the *with panic attacks* specifier. However, if unexpected panic attacks also occur, an additional diagnosis of panic disorder may be assigned.

Boundary with social anxiety disorder

In social anxiety disorder, symptoms occur in response to feared social situations (e.g. speaking in public, initiating a conversation), and the primary focus of apprehension is being negatively evaluated by others. Individuals with generalized anxiety disorder may worry about the implications of performing poorly or failing an examination but are not exclusively concerned about being negatively evaluated by others.

associated with pessimistic thoughts. Depressive disorders are differentiated by the presence of low mood or loss of pleasure in previously enjoyable activities, and by other characteristic symptoms of depressive disorders (e.g. appetite changes, feelings of worthlessness, suicidal ideation). Generalized anxiety disorder may co-occur with depressive disorders, but should only be diagnosed if the diagnostic requirements for generalized anxiety disorder were met prior to the onset of or following complete remission of a depressive episode.

Boundary with adjustment disorder

Adjustment disorder involves maladaptive reactions to an identifiable psychosocial stressor or multiple stressors characterized by preoccupation with the stressor or its consequences. Reactions may include excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications. Adjustment disorder centres on the identifiable stressor or its consequences, whereas in generalized anxiety disorder, worry typically encompasses multiple areas of daily life and may include hypothetical concerns (e.g. that a negative life event may occur). Unlike individuals with generalized anxiety disorder, those with adjustment disorder typically have normal functioning prior to the onset of the stressors. Symptoms of adjustment disorder generally resolve within 6 months.

Boundary with obsessive-compulsive disorder

In obsessive-compulsive disorder, the focus of apprehension is on intrusive and unwanted thoughts, urges or images (obsessions), whereas in generalized anxiety disorder the focus is on everyday life events. In contrast to obsessions in obsessive-compulsive disorder, which are usually experienced as unwanted and intrusive, individuals with generalized anxiety disorder may experience their worry as a helpful strategy in averting negative outcomes.

Boundary with hypochondriasis (health anxiety disorder) and bodily distress disorder

In hypochondriasis and bodily distress disorder, individuals worry about real or perceived physical symptoms and their potential significance to their health status. Individuals with generalized anxiety disorder experience somatic symptoms associated with anxiety and may worry about their health, but their worry extends to other aspects of everyday life.

Boundary with post-traumatic stress disorder

Individuals with post-traumatic stress disorder develop hypervigilance as a consequence of exposure to the traumatic stressor, and may become apprehensive that they or others close to them may be under immediate threat either in specific situations or more generally. Individuals with post-traumatic stress disorder may also experience anxiety triggered by reminders of the traumatic event (e.g. fear and avoidance of a place where an individual was assaulted). In contrast, the anxiety and worry in individuals with generalized anxiety disorder is directed towards the possibility of untoward events in a variety of life domains (e.g. health, finances, work).

6B01 Panic disorder

Essential (required) features

- Recurrent panic attacks, which are discrete episodes of intense fear or apprehension characterized by the rapid and concurrent onset of several characteristic symptoms, are required for diagnosis. These symptoms may include, but are not limited to, the following:
  - palpitations or increased heart rate
  - sweating
  - trembling
  - sensations of shortness of breath
  - feelings of choking
  - chest pain
  - nausea or abdominal distress
  - feelings of dizziness or lightheadedness
  - chills or hot flushes
  - tingling or lack of sensation in extremities (i.e. paraesthesias)
  - depersonalization or derealization
  - fear of losing control or going mad
  - fear of imminent death.
- At least some of the panic attacks are unexpected – that is, they are not restricted to particular stimuli or situations but rather seem to arise "out of the blue".
- Panic attacks are followed by persistent concern or worry (e.g. for several weeks) about their recurrence or their perceived negative significance (e.g. that the physiological symptoms may be those of a myocardial infarction), or by behaviours intended to avoid their recurrence (e.g. only leaving the home with a trusted companion).
- Panic attacks are not limited to anxiety-provoking situations in the context of another mental disorder.
- The symptoms are not a manifestation of another medical condition (e.g. pheochromocytoma), and are not due to the direct effects of a substance or medication on the central nervous system (e.g. coffee, cocaine), including withdrawal effects (e.g. alcohol, benzodiazepines).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Note: panic attacks can occur in other anxiety and fear-related disorders and in other mental disorders; therefore, the presence of panic attacks is not in itself sufficient to assign a diagnosis of panic disorder.

Additional clinical features

- Individual panic attacks usually only last for minutes, though some may last longer. The frequency and severity of panic attacks varies widely (e.g. many times per day to a few times per month) within and across individuals.
- In panic disorder, it is common for panic attacks to become more "expected" over time as they become associated with particular stimuli or contexts, which may originally have been coincidental. (For example, an individual who has an unexpected panic attack when crossing a bridge may subsequently become anxious when crossing bridges, which could then lead to "expected" panic attacks in response to bridges.)
- Limited-symptom attacks (i.e. attacks that are similar to panic attacks, except that they are accompanied by only a few symptoms characteristic of a panic attack without the characteristic intense peak of symptoms) are common in individuals with panic disorder, particularly as behavioural strategies (e.g. avoidance) are used to curtail anxiety symptoms. However, in order to qualify for a diagnosis of panic disorder, there must be a history of recurrent panic attacks that meet the full diagnostic requirements.
- Some individuals with panic disorder experience nocturnal panic attacks – that is, waking from sleep in a state of panic.
- Although the pattern of symptoms (e.g. mainly respiratory, nocturnal), the severity of the anxiety and the extent of avoidance behaviours are variable, panic disorder is one of the most impairing of the anxiety disorders. Individuals often present repeatedly for emergency care, and may undergo a range of unnecessary and costly special medical investigations despite repeated negative findings.

Boundary with normality (threshold)

- Panic attacks are common in the general population, particularly in response to anxiety-provoking life events. Panic attacks in response to real threats to an individual's physical or psychological integrity are considered part of the normative continuum of reactions, and a diagnosis is not warranted in such cases. Panic disorder is differentiated from normal fear reactions by frequent recurrence of panic attacks, persistent worry or concern about the panic attacks or their meaning, or alterations in behaviour (e.g. avoidance) and associated significant impairment in functioning.
- The sudden onset, rapid peaking, unexpected nature and intense severity of panic attacks differentiate them from normal situationally bound anxiety that may be experienced in everyday life (e.g. during stressful life transitions such as moving to a new city).

Course features

- Onset of panic disorder typically occurs during the early 20s.
- Some individuals experience episodic symptom outbreaks with long periods of remission, while others experience persistent, severe symptoms.
- The presence of co-occurring disorders (e.g. other anxiety and fear-related disorders, depressive disorders, disorders due to substance use) has been associated with poorer long-term course trajectory.
- A co-occurring diagnosis of agoraphobia is generally associated with greater symptom severity and a poorer long-term prognosis.

Developmental presentations

- Although some children report physical symptoms of panic attacks, panic disorder is very rare in younger children because cognitive capacity for catastrophizing about the significance of symptoms is not yet fully developed. The prevalence of panic disorder increases across adolescence and early adulthood.
- Adolescents with panic disorder are at greater risk of a co-occurring depressive disorder including suicidality, as well as of disorders due to substance use.

Culture-related features

- The symptom presentation of panic attacks may vary across cultures, influenced by cultural attributions about their etiology. For example, individuals of Cambodian origin may emphasize panic symptoms attributed to dysregulation of *khyâl*, a wind-like substance in traditional Cambodian ethnophysiology (e.g. dizziness, tinnitus, neck soreness).
- Several notable cultural concepts of distress are related to panic disorder; these link panic, fear or anxiety to etiological attributions regarding specific social and environmental influences. Examples include attributions related to interpersonal conflict (e.g. *ataque de nervios* among Latin American people), exertion or orthostasis (*khyâl cap* among Cambodians), and atmospheric wind (*trúng gió* among Vietnamese individuals). These cultural labels may be applied to symptom presentations other than panic (e.g. anger paroxysms, in the case of *ataque de nervios*), but they often constitute panic episodes or presentations with partial phenomenological overlap with panic attacks.
- Clarifying cultural attributions and the context of the experience of symptoms can inform whether panic attacks should be considered unexpected, as must be the case in panic disorder. For example, panic attacks may involve specific foci of apprehension that are better accounted for by another disorder (e.g. social situations in social anxiety disorder).

Moreover, the cultural linkage of the apprehension focus with specific exposures (e.g. wind or cold and *trúng gió* panic attacks) may suggest that acute anxiety is expected when considered within the individual's cultural framework.

Sex- and/or gender-related features

- Panic disorder is twice as prevalent among females as males, with gender differences in prevalence rates beginning during puberty.
- Gender differences in clinical features or symptom presentation have not been observed.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with generalized anxiety disorder

Some individuals with panic disorder may experience anxiety and worry between panic attacks. If the focus of the anxiety and worry is confined to fear of having a panic attack or the possible implications of panic attacks (e.g. that the individual may be suffering from a cardiovascular illness), an additional diagnosis of generalized anxiety disorder is not warranted. If, however, the individual is more generally anxious about a number of life events in addition to experiencing unexpected panic attacks, an additional diagnosis of generalized anxiety disorder may be appropriate.

Boundary with agoraphobia

During the early phase of panic disorder, panic attacks are often perceived as completely unpredictable or "out of the blue". However, over time, as panic attacks occur in specific situations, those situations become associated with the experience of intense anxiety. As a consequence, the individual may develop anticipatory anxiety about being in those situations, or exposure to those situations may actually trigger panic attacks. In this way, it is common for individuals with panic disorder to develop some degree of agoraphobic symptoms over time. If the individual develops fears that panic attacks or other incapacitating or embarrassing symptoms will occur in multiple situations, and as a result actively avoids these situations, requires the presence of a companion, or endures them only with intense fear or anxiety and all other diagnostic requirements for agoraphobia are met, an additional diagnosis of agoraphobia may be assigned.

Boundary with depressive disorders

Panic attacks can occur in depressive disorders – particularly in those with prominent anxiety symptoms, including mixed depressive and anxiety disorder – and may be triggered by depressive ruminations. If unexpected panic attacks occur in the context of these disorders and the main concern is about recurrence of panic attacks or the significance of panic symptoms, an additional diagnosis of panic disorder may be appropriate.

Boundary with hypochondriasis (health anxiety disorder)

Individuals with hypochondriasis often misinterpret bodily symptoms as evidence that they may have one or more life-threatening illnesses. Although individuals with panic disorder may

also manifest concerns that physical manifestations of anxiety are indicative of life-threatening illnesses (e.g. myocardial infarction), these symptoms typically occur in the midst of a panic attack. Individuals with panic disorder are more concerned about the recurrence of panic attacks or the significance of panic symptoms, are less likely to report somatic concerns attributable to bodily symptoms other than those associated with anxiety, and are less likely to engage in repetitive and excessive health-related behaviours. However, panic attacks can occur in hypochondriasis, and if they are exclusively associated with fears of having a life-threatening illness, an additional diagnosis of panic disorder is not warranted. In this situation, the *with panic attacks* specifier can be applied to the diagnosis of hypochondriasis. If there are persistent and repetitive panic attacks in the context of hypochondriasis that are unexpected in the sense that they are not in response to illness-related concerns, both diagnoses should be assigned.

Boundary with oppositional defiant disorder

Irritability, anger and noncompliance are sometimes associated with panic disorder in children and adolescents. For example, children may exhibit angry outbursts when presented with a task or situations that make them feel anxious (e.g. being asked to leave the home without a trusted companion such as a parent or caregiver). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear or panic, a diagnosis of oppositional defiant disorder is generally not appropriate.

Boundary with other mental, behavioural and neurodevelopmental disorders

Panic attacks can occur in the context of a variety of other mental disorders – particularly other anxiety and fear-related disorders, disorders specifically associated with stress, and obsessive-compulsive and related disorders. When panic attacks occur in the context of these disorders, they are generally part of an intense anxiety response to a distressing internal or external stimulus that represents a focus of apprehension in that disorder (e.g. a particular object or situation in specific phobia, fear of negative social evaluation in social anxiety disorder, fear of being contaminated by germs in obsessive-compulsive disorder, fear of having a serious illness in hypochondriasis, reminders of a traumatic event in post-traumatic stress disorder). If panic attacks are limited to such situations in the context of another disorder, a separate diagnosis of panic disorder is not warranted. If some panic attacks over the course of the disorder have been unexpected and not exclusively in response to stimuli associated with the focus of apprehension related to another disorder, an additional diagnosis of panic disorder may be assigned.

6B02 Agoraphobia

Essential (required) features

- Marked and excessive fear or anxiety that occurs in, or in anticipation of, multiple situations where escape might be difficult or help might not be available is required for diagnosis. Examples include using public transportation, or being in crowds, outside the home alone, in shops or theatres, or standing in line.
- The individual is consistently fearful or anxious about these situations due to a fear of specific negative outcomes such as panic attacks, symptoms of panic, or other incapacitating (e.g. falling) or embarrassing physical symptoms (e.g. incontinence).

- The situations are actively avoided, are entered only under specific circumstances (e.g. in the presence of a companion), or else are endured with intense fear or anxiety.
- The symptoms are not transient – that is, they persist for an extended period of time (e.g. at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g. paranoid ideation in delusional disorder, social withdrawal in depressive disorders).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- The experiences feared by individuals with agoraphobia may include symptoms of a panic attack as described in panic disorder (e.g. palpitations or increased heart rate, chest pain, feelings of dizziness or lightheadedness) or other symptoms that may be incapacitating, frightening, difficult to manage or embarrassing (e.g. incontinence, changes in vision, vomiting). It is often important to establish quite specifically the nature of the feared outcome in agoraphobia, as this may inform the specific choice of treatment strategies.
- It is common for individuals with agoraphobia to have a history of panic attacks, although they may not currently meet the diagnostic requirements for panic disorder, or indeed may not have panic attacks at all because they avoid situations in which panic attacks may occur. Establishing that an individual's focus of apprehension relates specifically to experiencing the bodily symptoms of a panic attack is important in considering whether to add components of panic disorder treatment (e.g. interoceptive exposure) to the treatment of agoraphobia, even when there is no current panic disorder diagnosis.
- Individuals with agoraphobia may employ a variety of different behavioural strategies if required to enter feared situations. One such "safety" behaviour is to require the presence of a companion. Other strategies may include going to certain places only at particular times of day, or carrying specific materials (e.g. medications, towels) in case of the feared negative outcome. These strategies may change over the course of the disorder and from one occasion to the next. For example, on different occasions in the same situation an individual may insist on having a companion, endure the situation with distress, or use various safety behaviours to cope with their anxiety.
- Although the pattern of symptoms, the severity of the anxiety and the extent of avoidance are variable, agoraphobia is one of the most impairing of the anxiety and fear-related disorders to the extent that some individuals become completely housebound; this has an impact on opportunities for employment, seeking medical care and the ability to form and maintain relationships.

Boundary with normality (threshold)

- Individuals may exhibit transient avoidance behaviours in the context of normal development or in periods of increased stress. These behaviours are differentiated from agoraphobia because they are limited in duration and do not lead to significant impact on functioning.
- Individuals with disabilities or medical conditions may avoid certain situations because of reasonable concerns about being incapacitated or embarrassed (e.g. a person with a mobility limitation who is concerned that an unfamiliar location will not be accessible, a person with Crohn disease who is concerned about experiencing sudden diarrhoea). Agoraphobia should only be diagnosed if the anxiety and avoidance result in functional impairment that is greater than expected given the disability or health condition.

Course features

- The typical age of onset for agoraphobia is in late adolescence, with the majority of individuals experiencing onset before 35 years of age. However, age of onset is later (during the mid- to late 20s) for individuals without a history of panic attacks or pre-existing diagnosis of panic disorder. Onset during childhood is considered rare.
- Agoraphobia is generally considered a chronic and persistent condition. The long-term course and outcome of agoraphobia is associated with increased risk of developing depressive disorders, dysthymic disorder and disorders due to substance use.
- Greater symptom severity (e.g. avoidance of most activities, being housebound) is associated with higher rates of relapse and chronicity, and a poorer long-term prognosis.
- The presence of co-occurring disorders – particularly other anxiety and fear-related disorders, depressive disorders, personality disorder and disorders due to substance use – has been associated with a poorer long-term prognosis.

Developmental presentations

- Although the clinical features of agoraphobia generally remain consistent across the lifespan, specific triggers and related cognitions can vary across age groups. For example, whereas fear of being outside the home alone or becoming lost are common during childhood, adults are more likely to fear standing in line, being in crowded or open spaces, or experiencing a panic attack. Among older adults, fear of falling is common.
- As with adults, children and adolescents with agoraphobia may demonstrate excessive avoidance of certain situations or locations, or require the presence of a close friend or family member to enter these situations. Children with agoraphobia are likely to resist leaving the

home without a parent or caregiver. A common focus of apprehension is becoming lost and not being able to obtain help. Soliciting information from collateral informants who know the child well can assist in clarifying the child's focus of apprehension.

Culture-related features

- Assessment of agoraphobia should incorporate information on cultural and gender norms. For example, fear of leaving the home among populations and contexts in which violence is common should not be assigned this diagnosis unless the fear is in excess of what is culturally normative. Likewise, for individuals in cultures who spend most of their time at home, anxiety when in open areas (e.g. markets) may be expected; the disorder should only be diagnosed when the fear exceeds cultural norms.

Sex- and/or gender-related features

- Lifetime prevalence of agoraphobia is approximately twice as high among women. Among children, it is more frequently reported in girls, with symptom onset occurring earlier for girls than boys.
- Men with agoraphobia are more likely to report co-occurring disorders due to substance use.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with panic disorder

It is common for individuals with panic disorder to develop some degree of agoraphobic symptoms over time. If the individual experiences recurrent unexpected panic attacks that are not restricted to particular stimuli or situations, and agoraphobic symptoms do not meet the full diagnostic requirements for agoraphobia, then panic disorder is the appropriate diagnosis. Conversely, many individuals with agoraphobia have experienced recurrent panic attacks. If an individual with agoraphobia experiences panic attacks exclusively in the context of the multiple agoraphobic situations without the presence of unexpected panic attacks, an additional diagnosis of panic disorder is not warranted, and the presence of panic attacks may be indicated using the *with panic attacks* specifier. However, if unexpected panic attacks also occur, an additional diagnosis of panic disorder may be assigned.

Boundary with specific phobia

Specific phobia is differentiated from agoraphobia because it involves fear of circumscribed situations or stimuli themselves (e.g. heights, animals, blood or injury) rather than fear or anxiety of imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation

or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

Boundary with social anxiety disorder

In social anxiety disorder, symptoms occur in response to feared social situations (e.g. speaking in public, initiating a conversation), and the primary focus of apprehension is being negatively evaluated by others.

Boundary with separation anxiety disorder

As with agoraphobia, individuals with separation anxiety disorder avoid situations but, in contrast, they do so to prevent or limit being away from individuals to whom they are attached (e.g. parent, spouse, or child) for fear of losing them.

Boundary with schizophrenia and other primary psychotic disorders

Individuals with schizophrenia and other primary psychotic disorders may avoid situations as a consequence of persecutory or paranoid delusions rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

Boundary with depressive disorders

In depressive disorders, individuals may avoid multiple situations, but do so because of loss of interest in previously pleasurable activities or due to lack of energy rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

Boundary with post-traumatic stress disorder

In post-traumatic stress disorder, the individual deliberately avoids reminders likely to produce re-experiencing of the traumatic event. In contrast, situations are avoided in agoraphobia because of fear or anxiety of imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation, or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

Boundary with oppositional defiant disorder

Irritability, anger and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to enter situations that make them feel anxious (e.g. being asked to leave the home without a trusted companion such as a parent or caregiver). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear or panic, a diagnosis of oppositional defiant disorder is generally not appropriate.

6B03 Specific phobia

Essential (required) features

- Marked and excessive fear or anxiety that consistently occurs upon exposure or anticipation of exposure to one or more specific objects or situations (e.g. proximity to certain kinds of animals, heights, enclosed spaces, sight of blood or injury), and that is out of proportion to the actual danger posed by the specific object or situation, is required for diagnosis.
- The phobic object or situation is actively avoided or else endured with intense fear or anxiety.
- A pattern of fear, anxiety or avoidance related to specific objects or situations is not transient – that is, it persists for an extended period of time (e.g. at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g. social anxiety disorder, a primary psychotic disorder).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Specific phobia encompasses fears of a broad and heterogeneous group of phobic stimuli. The most common are for particular animals (animal phobia), heights (acrophobia), enclosed spaces (claustrophobia), sight of blood or injury (blood-injury phobia), flying, driving, storms, darkness and medical/dental procedures. Individuals' reactions to phobic stimuli can range from feelings of disgust and revulsion (often occurring in animal phobias or blood-injury phobias), to anticipation of danger or harm (common across most types of specific phobia) and physical symptoms such as fainting (most common in response to blood or injury).
- The majority of individuals diagnosed with specific phobia report fear of multiple objects or situations. A single diagnosis of specific phobia is assigned regardless of the number of feared objects or situations. Unlike most phobic stimuli, which upon presentation or anticipation typically result in significant physiological arousal, individuals who fear the sight of blood, invasive medical procedures or injury may experience a vasovagal response that can result in a fainting spell.
- Some individuals with specific phobia may report a history of having observed another person (e.g. a caregiver) react with fear or anxiety when confronted by an object or situation, resulting in vicarious learning of a fear response to the object or situation. Others may have had a direct negative experience with an object or situation (e.g. having been bitten by a dog). However, previous negative experiences (direct or vicarious) are not necessary for the development of the disorder.

- Some individuals report that their fear or anxiety for an object or situation is not excessive. As such, clinicians must consider whether the reported fear, anxiety or avoidance behaviour is disproportionate to the reasonable risk of harm, taking into consideration both accepted cultural norms and the specific environmental conditions that the individual is normally subjected to (e.g. fear of darkness may be justified in a neighbourhood where assaults are common at night).

Boundary with normality (threshold)

- In children and adolescents, some fears may be part of normal development (e.g. a young child who is afraid of dogs). Specific phobia should only be diagnosed if the fear or anxiety is excessive in comparison to that of other individuals at a similar developmental level.

Course features

- Onset of specific phobia can occur at any age; however, initial onset is most common during early childhood (between 7 and 10 years of age), typically as a result of witnessing or experiencing a fear-provoking situation or event (e.g. choking, being attacked by an animal, witnessing someone drown).
- Younger age of onset has been associated with phobias related to animal and natural phenomena (fear of still water/weather, closed spaces), whereas fear of flying and height-related phobias generally have an older age of onset.
- Younger age of onset is also associated with an increased number of feared situations or stimuli.
- Individuals with specific phobia report high lifetime rates of co-occurring disorders – particularly depressive disorders and other anxiety and fear-related disorders. In the majority of cases, specific phobia precedes the onset of other mental disorders.
- Specific phobias that persist from childhood into adolescence and adulthood rarely remit spontaneously.

Developmental presentations

- Anxiety and fear-related disorders are the most prevalent mental disorders of childhood and adolescence. Among these conditions, specific phobia is one of the most common in young children, and may present in children as young as 3 years of age.
- In children, the diagnosis of specific phobia should not be assigned when the fears are developmentally normative (e.g. fear of the dark in young children).
- In preschool-aged children, phobic responses may include freezing, tantrums or crying. Duration, frequency and intensity of these reactions may be used to distinguish between age-typical fears and anxiety responses in specific phobia.

- Specific phobias related to tangible objects (e.g. animals) are more common in younger children, whereas those relating to possible harm to oneself or others (e.g. environmental, blood/injection) are more common in adolescents and adults.
- As with adults, excessive avoidance is seen in both children and adolescents, and may be driven by either the actual presence of the phobic stimuli or anticipatory anxiety (e.g. refusing to go outside because of the possible presence of bees).

Culture-related features

- Culture may play a role in shaping the fear response to specific stimuli. A diagnosis of specific phobia should not be assigned if a stimulus is feared by most people in a cultural group, unless the fear exceeds cultural norms. For example, people from some cultural groups may avoid walking at night in certain areas where they fear ghosts or spirits may be present.
- The salience of specific feared stimuli may differ by cultural group and environmental context. Common threats in the environment (e.g. poisonous snakes) may account for some of the cultural variation in feared stimuli.

Sex- and/or gender-related features

- Lifetime prevalence of specific phobia is approximately twice as high among females.
- Whereas males and females are equally likely to experience phobias related to blood, injection and injury, situationally specific phobias and those related to animals and natural environments are more common among females.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with panic disorder

If an individual with specific phobia experiences panic attacks exclusively in the context of actual or anticipated encounters with the specific object or situation that represents the focus of apprehension, an additional diagnosis of panic disorder is not warranted, and the presence of panic attacks may be indicated using the *with panic attacks* specifier. However, if unexpected panic attacks also occur, an additional diagnosis of panic disorder may be assigned.

Boundary with agoraphobia

Specific phobia is differentiated from agoraphobia because it involves fear of circumscribed situations or stimuli (e.g. heights, animals, blood-injury) rather than because of fear or anxiety of imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation

or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult.

Boundary with social anxiety disorder

In social anxiety disorder, the fear and avoidance are triggered by social situations (e.g. speaking in public, initiating a conversation), and the primary focus of apprehension is being negatively evaluated by others, whereas in specific phobia, the fear and avoidance is in response to other specific objects or situations.

Boundary with obsessive-compulsive disorder

In obsessive-compulsive disorder, individuals may avoid specific stimuli or situations related to obsessions or compulsions (e.g. avoiding "contaminated" situations in someone with a hand-washing compulsion), whereas in specific phobia, objects or situations are avoided because of fear associated with them and not because of obsessions or compulsions.

Boundary with hypochondriasis (health anxiety disorder)

In hypochondriasis, individuals may avoid medical consultations or hospitals because of a fear that it will exacerbate their preoccupation with having a serious disease. In contrast, in specific phobia the fear and avoidance are related to the specific object or situation itself.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

Both specific phobia and post-traumatic stress disorder involve avoidance of stimuli that cause anxiety, and both may arise following exposure to a traumatic event. Post-traumatic stress disorder can be differentiated from specific phobia by the presence of the other core symptoms of post-traumatic stress disorder (re-experiencing the trauma and persistent perceptions of heightened current threat). They are further differentiated by the fact that – unlike in specific phobia, in which the memories of the related traumatic event are experienced as belonging to the past – in post-traumatic stress disorder and complex post-traumatic stress disorder, the traumatic event is experienced as if it were occurring again in the here and now (i.e. re-experiencing).

Boundary with feeding and eating disorders

Individuals with feeding and eating disorders exhibit abnormal eating behaviour and/or preoccupation with food as well as prominent body weight or shape concerns, and may avoid food because they fear it will lead to weight gain or because of its specific sensory qualities. In some specific phobias, individuals may avoid eating or food stimuli, but the avoidance is related to the anticipated direct effect of the phobic stimulus (e.g. eating may lead to choking or vomiting) rather than because of the caloric content or sensory qualities of the food itself.

Boundary with oppositional defiant disorder

Irritability, anger and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to interact with a stimulus or enter situations that make them feel anxious (e.g. asking a child who fears dogs to go to the park where dogs might be present). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear or panic, a diagnosis of oppositional defiant disorder is generally not appropriate.

6B04 Social anxiety disorder

Essential (required) features

- Marked and excessive fear or anxiety that occurs consistently in one or more social situations such as social interactions (e.g. having a conversation), doing something while feeling observed (e.g. eating or drinking in the presence of others) or performing in front of others (e.g. giving a speech) is required for diagnosis.
- The individual is concerned that they will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e. be humiliating, be embarrassing, lead to rejection or be offensive).
- Relevant social situations are consistently avoided or endured with intense fear or anxiety.
- The symptoms are not transient – that is, they persist for an extended period of time (e.g. at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g. agoraphobia, body dysmorphic disorder, olfactory reference disorder).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Individuals with social anxiety disorder may report concerns about physical symptoms – such as blushing, sweating or trembling – rather than initially endorsing fears of negative evaluation.
- Social anxiety disorder frequently co-occurs with other anxiety and fear-related disorders and depressive disorders.
- Individuals with social anxiety disorder are at higher risk of developing disorders due to substance use, which may arise subsequent to use for the purposes of attenuating anxiety symptoms in social situations.
- Individuals with social anxiety disorder may not view their fear or anxiety in response to social situations as excessive. As such, clinical judgement should be applied to determine whether the reported fear, anxiety or avoidance behaviour is disproportionate to what the social situation warrants, taking into consideration both accepted cultural norms and the specific environmental circumstances to which the individual is subjected (e.g. fear of interacting with peers may be appropriate if the individual is being bullied).

Boundary with normality (threshold)

- Social anxiety disorder can be differentiated from normal developmental fears (e.g. a child's reluctance to interact with unfamiliar people in novel situations) by fear and anxiety reactions that are typically excessive, interfere with functioning, and persist over time (e.g. lasting more than several months).
- Many individuals experience fear in social situations (e.g. it is common for individuals to experience anxiety about speaking in public) or manifest the normal personality trait of shyness. Social anxiety disorder should only be considered in cases in which the individual reports social fear, anxiety, and avoidance that are clearly in excess of what is normative for the specific cultural context and result in significant distress or impairment.

Course features

- Although onset of social anxiety disorder can occur during early childhood, onset typically occurs during childhood and adolescence, with a large majority of cases emerging between 8 and 15 years of age.
- Onset of social anxiety disorder can be gradual or occur precipitously subsequent to a stressful or humiliating social experience.
- Social anxiety disorder is generally considered to be a chronic condition; however, later age of onset, less severe level of impairment and absence of co-occurring disorders have been associated with spontaneous remission among individuals in the community.
- High rates of co-occurring mental disorders make it difficult to distinguish long-term prognosis attributable specifically to social anxiety disorder. A poorer long-term prognosis has been associated with greater symptom severity and co-occurring disorders due to use of alcohol, personality disorder, generalized anxiety disorder, panic disorder and agoraphobia.
- Remission rates for social anxiety disorder vary widely, with some individuals experiencing spontaneous remission of symptoms.

Developmental presentations

- Social anxiety disorder is less prevalent among young children under the age of 10 years, with occurrence of the disorder increasing significantly during adolescence.
- In children, the diagnosis of social anxiety disorder should not be used to describe developmentally normative stranger anxiety or shyness.
- Social anxiety disorder is associated with the temperamental trait of behavioural inhibition – that is, the tendency for some individuals to experience novel situations as distressing and to withdraw from or avoid unfamiliar contexts or people. Behaviourally inhibited

children are "slow to warm up" to new people and new situations. Behavioural inhibition is considered to be a normal variation in temperament, but is also a risk factor for the development of social anxiety disorder.

- As with adults, children and adolescents may employ subtle avoidance strategies during social situations to manage their anxiety, including limiting speech or making poor eye contact with others. Children and adolescents with social anxiety disorder may also evidence social skills deficits, such as difficulty with starting or maintaining conversations or asserting their wishes or opinions.
- Social anxiety disorder symptoms may only become evident with the start of school, with the onset of demands to interact socially with unfamiliar peers and teachers. The manifestations of social anxiety disorder may also vary across age groups, with younger children more likely to exhibit social anxiety primarily with adults, and adolescents more likely to experience increased social anxiety with peers. There are also individual differences with respect to the degree of social anxiety experienced when interacting with members of the same or opposite sex. Soliciting information from collateral informants who know the child well about how they react in various situations and contexts can assist in making the diagnosis.
- Social anxiety disorder symptoms may become more evident with age, as social demands exceed individuals' capabilities to cope with and manage their anxiety. Adolescents may exhibit various associated difficulties, including social withdrawal, school refusal and reluctance to assert their needs. Some adolescents may participate in social situations for fear of the consequences to their social status if they do not, but do so with significant distress.

Culture-related features

- Identification of social anxiety disorder may depend on assessment of social situations relevant to the cultural group (e.g. being expected to dance in public among some Latin American cultures) that may be associated with excessive anxiety, and of whether the degree of anxiety is outside the cultural norms for the individual. To avoid stereotyping, individuals should be asked openly about social situations associated with excessive anxiety.
- Anxiety and avoidance of certain social situations may be considered normative in some cultural groups (e.g. public speaking or voicing dissent in some Asian cultures), and therefore may not indicate a disorder unless this fear or anxiety is out of proportion to the actual danger posed by the social situation when considering the sociocultural context.
- Some cultural concepts of distress are related to social anxiety disorder. For example, *taijin kyofusho* among Japanese people and related conditions among people in the Republic of Korea may represent a form of social anxiety disorder associated with the fear that others will be offended by one's own inappropriate social behaviour (e.g. inappropriate gaze or facial expression, blushing, body odour, loud bowel sounds). Other presentations of *taijin kyofusho* may be better captured by a diagnosis of delusional disorder, body dysmorphic disorder or olfactory reference disorder.
- Prevalence rates of social anxiety disorder may not follow self-reported social anxiety levels in the same culture – that is, societies with strong collectivistic orientations may report high levels of social anxiety but lower prevalence of social anxiety disorder. This may be due to higher tolerance for socially reticent and withdrawn behaviours, resulting in better psychosocial functioning, or to lower recognition of social anxiety disorder.

Sex- and/or gender-related features

- Whereas prevalence rates for social anxiety disorder are higher for women in community samples, gender differences are not observed in clinical samples. The disparity in prevalence across settings has been attributed to gender role expectations, such that men experiencing greater severity of symptoms are more willing to seek professional services.
- Women report greater symptom severity and a greater variety of social fears, whereas men are more likely to experience anxiety related to dating and urinating in public.
- Co-occurring depressive, bipolar and anxiety and fear-related disorders are more common among women, whereas men are more likely to experience co-occurring oppositional defiant disorder, conduct-dissocial disorder and disorders due to substance use.
- The use of alcohol and illicit drugs to relieve symptoms of social anxiety disorder is more common among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with generalized anxiety disorder

Generalized anxiety disorder can be differentiated from social anxiety disorder because the main focus of worry is negative consequences that can occur in multiple everyday situations (e.g. work, relationships, finances) rather than being restricted to concerns about one's behaviour or appearance being negatively evaluated in social situations.

Boundary with panic disorder

If an individual with social anxiety disorder experiences panic attacks exclusively in the context of actual or anticipated social or performance situations, an additional diagnosis of panic disorder is not warranted, and the presence of panic attacks may be indicated using the *with panic attacks* specifier. However, if unexpected panic attacks also occur, an additional diagnosis of panic disorder may be assigned.

Boundary with agoraphobia

Fear or anxiety in agoraphobia centres on imminent perceived dangerous outcomes (e.g. panic attacks, symptoms of panic, incapacitation or embarrassing physical symptoms) that are anticipated to occur in multiple situations where obtaining help or escaping might be difficult rather than on concerns about being negatively evaluated by others. Unlike social anxiety disorder, embarrassment in agoraphobia is secondary to concerns that escape or obtaining assistance may not be possible should symptoms (e.g. diarrhoea in a public place) occur.

Boundary with specific phobia

Specific phobia can be differentiated from social anxiety disorder because, in general, fears are of specific situations or stimuli (e.g. heights, animals, blood-injury) and not of social situations.

Boundary with selective mutism

Selective mutism is characterized by a failure to speak in specific situations, whereas in social anxiety disorder fear and anxiety result in avoidance of multiple social contexts.

Boundary with autism spectrum disorder

Individuals with autism spectrum disorder and social anxiety disorder may both appear to be socially withdrawn. However, those with autism spectrum disorder can be differentiated because of the presence of social communication deficits and, typically, a lack of interest in social interactions.

Boundary with depressive disorders

Beliefs of social inadequacy, rejection and failure are common in depressive disorders, and may be associated with avoidance of social situations. However, unlike in social anxiety disorder, these symptoms occur almost exclusively during a depressive episode.

Boundary with body dysmorphic disorder

In body dysmorphic disorder, individuals worry about a perceived physical defect that is often undetectable or very minor from the point of view of others. These individuals may be concerned about others' negative judgement of the perceived defect. However, unlike in social anxiety disorder, their concerns are restricted to how others will evaluate the perceived defect rather than other aspects of their behaviour or appearance across social contexts.

Boundary with olfactory reference disorder

In social anxiety disorder, social situations are avoided because the individual is concerned that they will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e. be humiliating, be embarrassing, lead to rejection or be offensive). In contrast, individuals with olfactory reference disorder may avoid social situations specifically because they believe they are emitting a foul odour.

Boundary with oppositional defiant disorder

Irritability, anger and noncompliance are sometimes associated with anxiety in children and adolescents. For example, children may exhibit angry outbursts when asked to enter situations that make them feel anxious (e.g. being asked to attend a social gathering). If the defiant behaviours only occur when triggered by a situation or stimulus that elicits anxiety, fear or panic, a diagnosis of oppositional defiant disorder is generally not appropriate.

Boundary with other mental and behavioural syndromes due to another medical condition

Individuals with certain medical conditions (e.g. Parkinson disease) and those with other mental, behavioural and neurodevelopmental disorders (e.g. schizophrenia) may demonstrate avoidance of social situations because of concerns that others will negatively evaluate their symptoms (e.g. tremor, unusual behaviours). An additional diagnosis of social anxiety disorder should only be assigned if all diagnostic requirements are met, taking into consideration that it is normal for individuals with visible symptoms of a medical condition to experience some concerns about how others perceive their symptoms. Typically, individuals with medical conditions adapt to concerns related to their manifest symptoms and do not display persistent excessive fear or anxiety in social situations.

6B05 Separation anxiety disorder

Essential (required) features

- Marked and excessive fear or anxiety about separation from those individuals to whom the person is attached (i.e. with whom the individual has a deep emotional bond) is required for diagnosis. In children and adolescents, key attachment figures that are most commonly the focus of separation anxiety include parents, caregivers and other family members, and the fear or anxiety is beyond what would be considered developmentally normative. In adults, separation anxiety most often involves a spouse, romantic partner or children. Manifestations of fear or anxiety related to separation depend on the individual's developmental level, but may include:
  - persistent thoughts that harm or some other untoward event (e.g. being kidnapped) will lead to separation;
  - reluctance or refusal to go to school or work;
  - recurrent excessive distress (e.g. tantrums, social withdrawal) related to being separated from the attachment figure;
  - reluctance or refusal to go to sleep without being near the attachment figure;
  - recurrent nightmares about separation;
  - physical symptoms such as nausea, vomiting, stomach pain or headache on occasions that involve separation from the attachment figure, such as leaving home to go to school or work.
- The symptoms are not transient – that is, they persist for an extended period of time (e.g. at least several months).
- The symptoms are not better accounted for by another mental disorder (e.g. agoraphobia, personality disorder).
- The symptoms result in significant distress about experiencing persistent anxiety symptoms or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Separation anxiety disorder frequently co-occurs with other mental, behavioural and neurodevelopmental disorders. In children and adolescents, common co-occurring disorders include generalized anxiety disorder and specific phobia. In adults, frequently co-occurring disorders include mood disorders, other anxiety and fear-related disorders, post-traumatic stress disorder and personality disorder.

- Although separation anxiety disorder may exhibit a lifelong course with onset in childhood, a significant proportion of adults with separation anxiety disorder do not recall a childhood onset.
- Separation anxiety disorder in childhood is frequently associated with a parenting style that interferes with the development of autonomy and self-mastery expected for that person's cultural context (e.g. the parent does not permit the child to engage independently in basic activities of daily living such as dressing and bathing).

Boundary with normality (threshold)

- Many situations involving separation are associated with other potential stressors or are normal sources of anxiety (e.g. leaving home to start a job or attend university in a new city). Separation anxiety disorder is differentiated based on the focus of apprehension being on separation from a key attachment figure rather than on other aspects of adjusting to novel circumstances.
- Strong attachment to loved ones is a normal and healthy part of life, and separation from these individuals may be associated with transient sadness or anxiety. Preschool-aged children may show a moderate or even greater degree of anxiety over real or threatened separation from people to whom they are attached. These reactions are considered developmentally appropriate, and are differentiated from separation anxiety disorder on the basis of the persistence of the symptoms (e.g. lasting for several months) with repeated separations, evidence of excessive preoccupations about the well-being of attachment figures, persistent avoidance, and significant distress or impairment in functioning as a consequence of the symptoms.
- Among children and adolescents, school refusal is a common occurrence, and may be based on transient anxiety about separation from a loved one or be symptomatic of separation anxiety disorder. However, especially in adolescence, anxiety about school or school refusal is not typically related to fear of separation but rather to other factors such as truancy, peer rejection or bullying.

Course features

- The typical onset of separation anxiety disorder is during childhood, and the disorder can persist into adulthood. Initial disorder onset during adolescence and adulthood may be less common.
- Separation anxiety disorder has been associated with elevated risk of developing a wide range of internalizing disorders, including depressive disorders, bipolar disorders and anxiety and fear-related disorders. There is also evidence of elevated risk of disruptive behaviour and dissocial disorders, and attention deficit hyperactivity disorder.

Developmental presentations

- Anxiety and fear-related disorders are the most prevalent mental disorders of childhood and adolescence. Among these disorders, separation anxiety disorder is one of the most common in young children.
- In children, the diagnosis of separation anxiety disorder should not be used to describe developmentally normative phenomena.
- The focus of apprehension in separation anxiety disorder may differ across age groups, such that younger children may demonstrate less credible fears (e.g. worrying about sleeping alone for fear they will be kidnapped in the middle of the night), whereas older children and adolescents may have more credible fears (e.g. parents being in a car accident).
- Symptom presentation varies with age. In younger children, who are less able to express worries or fears, behavioural manifestations of recurrent excessive distress are typically more prominent, such as tantrums or crying when separated from parents and caregivers. When at home, younger children may insist on following caregivers closely, exhibiting distress even when in a different room or on a different floor from parents or caregivers. Older children are usually able to express their preoccupations about separation from attachment figures or fears related to specific dangers (e.g. accidents, kidnapping, mugging, death). Older children and adolescents may be more likely to demonstrate social withdrawal, insisting on staying at home with family members rather than spending time with peers.

Culture-related features

- Cultural variation exists with regard to tolerating separation from attachment figures. In some cultural groups, it would be considered inappropriate to spend time apart from family or loved ones. Distress associated with separation in this sociocultural context should not be considered excessive if it is culturally normative.
- Children in some cultures remain in their parental home longer than in other cultures, and generally this trend is increasing globally, so the assignment of disorder should take into account cultural norms.

Sex- and/or gender-related features

- Although lifetime prevalence rates for separation anxiety disorder are slightly higher among females than males (5.6% versus 4%), during childhood, school refusal is equally prevalent for both genders.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with generalized anxiety disorder

Individuals with generalized anxiety disorder experience chronic and excessive worry about a variety of everyday life events that can include preoccupation about the safety of key attachment figures. However, these concerns seldom occur without additional worries regarding other domains of everyday life.

Boundary with panic disorder

If an individual with separation anxiety disorder experiences panic attacks exclusively in the context of separation from key attachment figures, an additional diagnosis of panic disorder is not warranted, and the presence of panic attacks may be indicated using the *with panic attacks* specifier. However, if unexpected panic attacks also occur, an additional diagnosis of panic disorder may be assigned.

Boundary with agoraphobia

In agoraphobia, individuals avoid a variety of situations, including leaving home alone, but the fear or anxiety is centred on the possibility that help will not be available in the event of a panic attack or other incapacitating or embarrassing symptoms rather than concerns about separation from key attachment figures.

Boundary with social anxiety disorder

In social anxiety disorder, the avoidance of social situations is in response to fear or anxiety about being negatively evaluated by others rather than concerns about being separated from key attachment figures.

Boundary with depressive disorders

Beliefs of social inadequacy, rejection and failure are common in depressive disorders, and may be associated with avoidance of leaving the home and being separated from loved ones. However, unlike in separation anxiety disorder, these symptoms occur almost exclusively during a depressive episode.

Boundary with post-traumatic stress disorder

In post-traumatic stress disorder, individuals have a history of exposure to a traumatic event that may have involved the loss of a key attachment figure. However, the focus of apprehension is on intrusive re-experiencing of the traumatic event from memory and avoidance of associated stimuli rather than concerns about future loss of or harm coming to the key attachment figure. Nevertheless, separation anxiety disorder rather than post-traumatic stress disorder may occur subsequent to the experience of a traumatic event, and if all diagnostic requirements are met, the diagnosis can be assigned.

Boundary with disruptive behaviour and dissocial disorders

Individuals with oppositional defiant disorder can exhibit similar behaviours to those observed in separation anxiety disorder, such as anger, irritability and temper outbursts, or defiant and headstrong behaviour (e.g. refusal to leave home or go to school). However, in separation anxiety disorder these occur exclusively as a result of anticipated or actual separation from a key attachment figure. School refusal or truancy may occur in the context of conduct-dissocial disorder, but the behaviour is not related to concerns for the well-being of a key attachment figure.

Boundary with personality disorder

Fear of abandonment or dependency on others can occur as symptoms of an enduring maladaptive pattern of behaviour associated with personality disorder. These symptoms tend to occur with other broader disruptions to interpersonal functioning, emotion regulation, and identity formation and definition. Personality disorder may co-occur with separation anxiety disorder and, if present, can be diagnosed separately.

6B06 Selective mutism

Essential (required) features

- Consistent selectivity in speaking, such that a child demonstrates adequate language competence in specific social situations (typically at home) but consistently fails to speak in others (typically at school) is required for diagnosis.
- The duration of the disturbance is at least 1 month, not limited to the first month of school.
- The disturbance is not due to a lack of knowledge of, or comfort with, the spoken language demanded in the social situation.
- The symptoms are not better accounted for by another mental disorder (e.g. a neurodevelopmental disorder such as autism spectrum disorder or developmental language disorder).
- Selectivity of speech is sufficiently severe to interfere with educational achievement or with social communication, or is associated with significant impairment in other important areas of functioning.

Additional clinical features

- Symptoms of selective mutism may interfere with direct assessment of expressive language. However, many affected children cooperate with receptive language testing if communication is restricted to carrying out commands or pointing to pictures, which can provide valuable information about a child's general language levels. Furthermore, reports from informants who know the child well (e.g. a parent or caregiver) may be necessary to establish that the child can speak in certain social situations.
- Selective mutism is often regarded as a variant of social anxiety disorder because affected individuals experience significant anxiety in social situations and, when able to express themselves, indicate that they fear negative evaluation – in particular of their speech. However, unlike social anxiety disorder, children with selective mutism are more likely to display these difficulties at an earlier age of onset (in most cases before the age of 5 years, although it may only become apparent when starting school), are more likely to have associated subtle language impairments, and exhibit oppositional behaviour in response to being asked to speak in feared situations.

- Co-occurrence with other anxiety and fear-related disorders (particularly social anxiety disorder, separation anxiety disorder and specific phobias) is very common among individuals with selective mutism.
- Selective mutism is associated with severe impairment in academic and social functioning that can manifest as inability to complete expected schoolwork, not getting needed assistance or support (because the child does not ask for it), inability to initiate or reciprocate social interactions with peers, or becoming the target of bullying.
- Social anxiety, withdrawal and avoidance in selective mutism may be related to temperamental factors such as behavioural inhibition and negative affectivity.

Boundary with normality (threshold)

- Transient reluctance to speak at the time of first starting school is a common occurrence. Selective mutism should only be diagnosed if symptoms persist beyond the first month of schooling. Immigrant children who are unfamiliar with or uncomfortable in the official language of their new host country may, for a discrete period of time, refuse to speak to strangers in their new environment. This may also occur with children from linguistic minorities. Selective mutism should not be diagnosed in such cases.

Course features

- Although the onset of selective mutism typically occurs during early childhood (i.e. prior to the age of 5 years), significant impairment of functioning may not manifest until entry into school, when children experience increased demands to speak publicly (e.g. reading aloud) and engage socially.
- A majority of children with selective mutism will present with symptoms of another anxiety or fear-related disorder – particularly social anxiety disorder.
- Children with selective mutism may also display signs of oppositionality – particularly in situations requiring speech. A co-occurring diagnosis of oppositional defiant disorder should not be assigned if refusal to speak can be entirely accounted for by features of selective mutism.
- The course of selective mutism varies among individuals. Although the average duration of the disorder is 8 years, after which symptoms begin to dissipate or remit completely, some individuals may experience a persistence of symptoms or a manifestation of another disorder – primarily social anxiety disorder.
- Even after the core symptoms of selective mutism resolve, individuals often continue to experience difficulties related to social communication and anxiety.
- A poorer prognosis is associated with a family history of selective mutism.

Culture-related features

- People in cultures with a high level of shame-based emotions may avoid speaking about particular topics or in situations that would evoke shame for themselves or others. When this is culturally normative, it should not be considered to be reflective of selective mutism.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with developmental speech and language disorders

Selective mutism is differentiated from the range of developmental speech and language disorders (i.e. language disorders or speech fluency disorder) that involve impairments in expressive language across all social situations. Although some children with selective mutism exhibit expressive language difficulties or phonological problems, these are often subtle, and functioning is usually found to be in the normal range. Selective mutism may occur in the presence of developmental speech and language disorders, and both can be diagnosed if warranted.

Boundary with autism spectrum disorder and disorders of intellectual development

Some individuals affected by autism spectrum disorder or disorders of intellectual development exhibit impairments in language and social communication. However, unlike in selective mutism, when language and communication impairments are present in autism spectrum disorder and disorders of intellectual development, they are notable across environments and social situations.

Boundary with schizophrenia and other primary psychotic disorder

Individuals with schizophrenia and other primary psychotic disorders may exhibit disruptions in speech and social communication as a function of symptoms of disordered thought. Unlike individuals with selective mutism, those with disrupted communication in the context of psychotic disorders display similar disruptions to speech across all social situations.

Boundary with social anxiety disorder

Selective mutism is characterized by a failure to speak in specific situations, whereas in social anxiety disorder fear and anxiety result in avoidance of multiple social contexts.

6B0Y Other specified anxiety or fear-related disorder

Essential (required) features

- The presentation is characterized by anxiety symptoms that share primary clinical features with other anxiety and fear-related disorders (e.g. physiological symptoms of excessive arousal, apprehension and avoidance behaviour).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the anxiety and fear-related disorders grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a mood disorder, an obsessive-compulsive or related disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6B0Z Anxiety or fear-related disorder, unspecified

Specifier for anxiety and fear-related disorders

MB23.H with panic attacks

This specifier can be applied to indicate the presence of panic attacks within the past month that manifest in the context of anxiety and fear-related disorders, as well as other disorders such as obsessive-compulsive and related disorders. The *with panic attacks* specifier should not be assigned when panic attacks can be entirely explained by a panic disorder diagnosis. Recurrent panic attacks that occur in the context of other mental disorders may be indicative of greater severity of psychopathology, poorer response to treatment and greater risk of suicide in the context of mood disorders.

When panic attacks occur in the context of other *anxiety and fear-related disorders*, they are conceptualized as episodes of severe anxiety that occur specifically in response to exposure

to, or anticipation of exposure to, the feared stimulus or stimuli (i.e. they reflect the focus of apprehension specific to the disorder). For example, panic attacks may occur in separation anxiety disorder during separation from a caregiver or partner, when exposed to the phobic situation or stimulus in specific phobia, or when entering social situations or speaking in public in social anxiety disorder. If panic attacks are limited to these types of situations, the *with panic attacks* specifier should be applied rather than an additional co-occurring diagnosis of panic disorder.

If some panic attacks over the course of the disorder have been unexpected and not exclusively in response to stimuli associated with the focus of apprehension related to the relevant disorder, a separate diagnosis of panic disorder should be assigned. In such cases, it is not necessary to apply the *with panic attacks* specifier.

For anxiety and fear-related disorders, application of the *with panic attacks* specifier produces the following combinations. (The *with panic attacks* specifier is not generally applicable to selective mutism.)

6B00/MB23.H	Generalized anxiety disorder with panic attacks
6B02/MB23.H	Agoraphobia with panic attacks
6B03/MB23.H	Specific phobia with panic attacks
6B04/MB23.H	Social anxiety disorder with panic attacks
6B05/MB23.H	Separation anxiety disorder with panic attacks
6B0Y/MB23.H	Other specified anxiety or fear-related disorder with panic attacks
6B0Z/MB23.H	Anxiety or fear-related disorder, unspecified, with panic attacks

Obsessive-compulsive and related disorders

The disorders in the obsessive-compulsive and related disorders grouping are characterized by repetitive thoughts and behaviours. Although these also have some features in common with disorders in other groupings (e.g. anxiety and fear-related disorders), those included in the grouping of obsessive-compulsive and related disorders have commonalities on key diagnostic validators and frequently co-occur, which may be related in part to shared genetic factors.

Cognitive phenomena such as obsessions, intrusive thoughts and preoccupations are central to a subset of these conditions (obsessive-compulsive disorder, body dysmorphic disorder, hypochondriasis and olfactory reference disorder), and are accompanied by related repetitive behaviours. Hoarding disorder is not associated with intrusive unwanted thoughts but rather characterized by a compulsive need to accumulate possessions and by distress related to discarding them. Also included in the grouping are body-focused repetitive behaviour disorders, which are primarily characterized by recurrent and habitual actions directed at the integument (e.g. hair pulling, skin picking) and lack a prominent cognitive aspect.

Obsessive-compulsive and related disorders include the following:

6B20 Obsessive-compulsive disorder

6B21 Body dysmorphic disorder

6B22 Olfactory reference disorder

6B23 Hypochondriasis (health anxiety disorder)

6B24 Hoarding disorder

6B25 Body-focused repetitive behaviour disorders

- 6B25.0 Trichotillomania (hair-pulling disorder)
- 6B25.1 Excoriation (skin-picking) disorder
- 6B25.Y Other specified body-focused repetitive behaviour disorder
- 6B25.Z Body-focused repetitive behaviour disorder, unspecified

6B2Y Other specified obsessive-compulsive or related disorder

6B2Z Obsessive-compulsive or related disorder, unspecified.

8A05.00 Tourette syndrome

The level of insight an individual has with respect to disorder-specific beliefs varies, and can be specified for those obsessive-compulsive and related disorders in which cognitive phenomena are a key aspect of clinical phenomenology. These include obsessive-compulsive disorder, body dysmorphic disorder, olfactory reference disorder, hypochondriasis and hoarding disorder. The level of insight may be specified as *fair to good* or *poor to absent*, as described for each of these disorders.

In addition, Tourette syndrome, classified in the grouping primary tics and tic disorders in Chapter 8 on diseases of the nervous system, is cross-listed here because of its high co-occurrence, familial association and analogous phenomenology (i.e. premonitory urges and repetitive behaviours) with obsessive-compulsive disorder:

6B20 Obsessive-compulsive disorder

Essential (required) features

- The presence of persistent obsessions and/or compulsions is required for diagnosis.
  - Obsessions are repetitive and persistent thoughts (e.g. of contamination), images (e.g. of violent scenes) or impulses/urges (e.g. to stab someone) that are experienced as intrusive and unwanted, and are commonly associated with anxiety. The individual typically attempts to ignore or suppress obsessions or to neutralize them by performing compulsions.
  - Compulsions are repetitive behaviours or rituals, including repetitive mental acts, that the individual feels driven to perform in response to an obsession, according to rigid rules, or to achieve a sense of "completeness". Examples of overt behaviours include repetitive washing, checking and ordering of objects. Examples of analogous mental acts include mentally repeating specific phrases in order to prevent negative outcomes, reviewing a memory to make sure that one has caused no harm, and mentally counting objects. Compulsions are either not connected in a realistic way to the feared event (e.g. arranging items symmetrically to prevent harm to a loved one) or are clearly excessive (e.g. showering daily for hours to prevent illness).
- Obsessions and compulsions are time-consuming (e.g. take more than 1 hour per day) or result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g. basal ganglia ischaemic stroke), and are not due to the effects of a substance or medication on the central nervous system (e.g. amfetamine), including withdrawal effects.

Insight specifiers

Individuals with obsessive-compulsive disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their obsessive-compulsive symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of a small minority of individuals with obsessive-compulsive disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g. an individual is convinced that they will become seriously ill if they do not maintain their washing rituals). Insight may vary substantially even over short periods of time – for example, depending on the level of current anxiety or distress – and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g. a few days or a week). The degree of insight that an individual exhibits in the context of obsessive-compulsive disorder can be specified as follows.

6B20.0 Obsessive-compulsive disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true, and they are willing to accept an alternative explanation for their experience. This specifier level may still be applied if, at circumscribed times (e.g. when highly anxious), the individual demonstrates no insight.

6B20.1 Obsessive-compulsive disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true, and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

6B20.Z Obsessive-compulsive disorder, unspecified

Additional clinical features

- The content of obsessions and compulsions varies among individuals, and can be grouped into different themes or symptom dimensions, including cleaning (i.e. contamination obsessions and cleaning compulsions); symmetry (i.e. symmetry obsessions and repeating, ordering and counting compulsions); forbidden or taboo thoughts (e.g. aggressive, sexual and religious obsessions) and related compulsions. Some individuals have difficulties discarding objects, and accumulate (i.e. hoard) them as a consequence of typical obsessions, such as fears of harming others (see boundary with other obsessive-compulsive and related disorders under hoarding disorder). Individuals usually manifest symptoms on more than one dimension.

- Although compulsions are not done for pleasure, their performance may result in temporary relief from anxiety or distress, or a temporary sense of completeness.
- Individuals with obsessive-compulsive disorder experience a range of affects when confronted with situations that trigger obsessions and compulsions. These affects can include marked anxiety or panic attacks, strong feelings of disgust or a distressing sense of "incompleteness" or uneasiness until things look, feel or sound "just right".
- Individuals with obsessive-compulsive disorder often avoid people, places and things that trigger obsessions and compulsions.
- Common beliefs in obsessive-compulsive disorder include an inflated sense of responsibility, overestimation of threat, perfectionism, intolerance of uncertainty and overvaluation of the power of thoughts (e.g. believing that having a forbidden thought is as bad as acting on it).
- The severity of obsessive-compulsive disorder symptomatology varies such that some individuals spend a few hours per day obsessing or engaging in compulsions, whereas others have near constant intrusive thoughts or compulsions that can be incapacitating.
- When both obsessions and compulsions are present there is typically a discernible relationship between them in content or temporal sequence. Compulsions are most often performed in response to obsessions (e.g. excessive hand washing due to fear of contamination). However, in some individuals with obsessive-compulsive disorder, particularly during the initial phase of the disorder, compulsions may precede the manifestation of obsessions. For example, an individual begins to feel that they must be afraid of an accidental fire because they repeatedly check the gas knob on the stove, or an individual concludes that they must be afraid of contamination based on the evidence of their repeated hand washing. Understanding the relationship between obsessions and compulsions can assist in intervention selection and treatment planning.

Boundary with normality (threshold)

- Intrusive thoughts, images and impulses/urges, as well as repetitive behaviours, are prevalent among the general population (e.g. thoughts of harming a loved one, double-checking that the door is locked). Obsessive-compulsive disorder should only be diagnosed when obsessions and compulsions are time-consuming (e.g. take more than 1 hour per day), cause significant distress or result in functional impairment.
- Developmentally normative preoccupations (e.g. worrying about interacting with strangers in young children) and rituals (e.g. skipping over cracks in a sidewalk) should not be attributed to a presumptive diagnosis of obsessive-compulsive disorder. These are differentiated from obsessions and compulsions characteristic of obsessive-compulsive disorder because they are transient, age-appropriate and not time-consuming (e.g. taking more than hour per day), and they do not result in significant distress or impairment.

Course features

- Obsessive-compulsive disorder typically has an age of onset in the late teens and early 20s, with late onset (after 35 years of age) less common. In cases of late onset, there is often a history of chronic subclinical symptoms.

- Onset of obsessive-compulsive disorder symptoms is often gradual. Sudden or late onset, in particular, should prompt additional assessment to differentiate obsessive-compulsive disorder from other medical conditions (e.g. basal ganglia ischaemic stroke) that may better explain the symptoms.
- Many adults with obsessive-compulsive disorder (30–50%) report a childhood onset of symptoms. For those with onset during childhood or adolescence, 40% may experience remission of symptoms by early adulthood.
- Obsessive-compulsive disorder in adults is generally considered a chronic condition, with waxing and waning of symptoms. Some experience an episodic course and a minority experience a worsening course.

Developmental presentations

- Onset before the age of 10 years is more common among males (approximately 25%), whereas adolescent onset is more likely among females. Younger age of onset is associated with greater genetic loading and poorer outcomes due to interference of symptoms with achieving developmental milestones (e.g. forming peer relationships, acquiring academic skills). Although childhood-onset obsessive-compulsive disorder typically follows a chronic course, particularly if left untreated, symptoms tend to wax and wane and many (approximately 40%) experience full remission by early adulthood. Among older adults, the prevalence of obsessive-compulsive disorder is slightly higher among men than women.
- Although precipitous onset of obsessive-compulsive disorder symptoms in children and adolescents has been reported, often attributed to paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), development of symptoms is typically gradual.
- The content and type of obsessions and compulsions varies across the lifespan. Children and adolescents are more likely to report obsessions centred upon bad things happening to their loved ones (e.g. parents), whereas adolescents and adults are more likely to report religious or sexual obsessions. Among children and adolescents, females are more likely to report symptoms centred upon contamination or cleaning, whereas males are more likely to report symptoms of a sexual, religious or aggressive nature. It may be easier to assess for the presence of compulsions in children because their level of cognitive development may preclude verbalizing content of obsessions.
- Among children and adolescents, the course of obsessive-compulsive disorder is frequently complicated by the co-occurrence of other mental disorders, the presence of which may affect identification of obsessive-compulsive disorder among young people. Up to 30% of all individuals with obsessive-compulsive disorder will also experience Tourette syndrome or another primary tic disorder during their lifetime. Co-occurring tics are more common among males with childhood-onset obsessive-compulsive disorder. Children and adolescents are also more likely than adults to present with a combination of obsessive-compulsive disorder, a primary tic disorder and/or attention deficit hyperactivity disorder. Body dysmorphic disorder or hoarding disorder often co-occur among adolescents with obsessive-compulsive disorder. Approximately half of elderly patients with obsessive-compulsive disorder exhibit ordering, hoarding and checking behaviours, which may also reflect symptoms of personality disorder with anankastic traits.

Culture-related features

- Similar types of obsessive-compulsivity disorder symptoms (e.g. concerns with contamination) are present cross-culturally, but cultural variation exists in the salience and prevalence of certain themes of content of obsessions and compulsions. For example, aggressive obsessions have been found to predominate in Brazil, and religious/scrupulosity concerns in Middle Eastern settings. In addition, scrupulosity obsessions may be more distressing among individuals of certain faith groups that emphasize ritual exactitude or the sinful nature of certain kinds of thoughts. The influence of culture may lead to the adoption of specific themes, such as obsessions about *kashrut* (dietary restrictions) observances among Jews, or about being in a state of uncleanliness (*napak*) among Muslims. Distinguishing religious compulsions from zealous but normative religious practice may require the help of religious experts aware of local norms.
- Etiological attributions may vary across social groups, including biological, psychological, social and supernatural or spiritual explanations. These attributions may also shape the specific obsessions, such as concerns about being deserving of punishment as the result of a transgression or the object of sorcery, witchcraft or the evil eye. In some cultural groups, compulsions may be reinforced by the belief that such acts ward off evil spirits or have another spiritual function.
- Help-seeking behaviour and clinical disclosure are less likely when the obsessions or compulsions are considered by the individual to be culturally taboo.

Sex- and/or gender-related features

- Males are more likely to experience obsessive-compulsive disorder during childhood, with approximately 25% experiencing onset before the age of 10 years. During adulthood, prevalence is higher among females.
- Males are more likely to experience co-occurring primary tic disorders.
- Gender differences in the specific content of obsessions and compulsions have been reported, whereby females are more likely to report cleaning and contamination-related themes, and males are more likely to report symmetry-related themes and taboo intrusive thoughts (e.g. violent impulses, sacrilegious images).
- Onset or exacerbation of obsessive-compulsive disorder has been reported during the peripartum period.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hypochondriasis (health anxiety disorder)

Hypochondriasis is characterized by persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses. Although obsessions in obsessive-compulsive disorder may be health-related, when these occur, they tend to be focused more on potential contamination than on the undiagnosed symptoms of a particular illness, and to be accompanied by a history of other obsessions that are not health-related.

Boundary with other obsessive-compulsive and related disorders

Recurrent thoughts and repetitive behaviours occur in other obsessive-compulsive and related disorders, but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In body dysmorphic disorder, the intrusive thoughts and repetitive behaviours are limited to concerns about physical appearance. In trichotillomania or excoriation disorder, the repetitive behaviours are limited to hair pulling or skin picking, respectively, in the absence of obsessions. Hoarding disorder symptoms include excessive accumulation or difficulty discarding possessions and marked distress related to discarding items. Hoarding behaviour can be symptomatic of obsessive-compulsive disorder, but in contrast to hoarding disorder it is undertaken with the goal of neutralizing or reducing concomitant distress and anxiety arising from obsessional content such as aggressive (e.g. fear of harming others), sexual/religious (e.g. fear of committing blasphemous or disrespectful acts), contamination (e.g. fear of spreading infectious diseases) or symmetry/ordering (e.g. feeling of incompleteness) themes. However, obsessive-compulsive and related disorders can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.

Boundary with autism spectrum disorder

Persistent repetitive thoughts, images or impulses/urges (i.e. obsessions) and/or repetitive behaviours (i.e. compulsions) characteristic of obsessive-compulsive disorder may be difficult to distinguish from restricted, repetitive and inflexible patterns of behaviour, interests or activities that are characteristic of autism spectrum disorder. However, unlike those with autism spectrum disorder, individuals with obsessive-compulsive disorder feel driven to perform repetitive behaviours in response to an obsession, according to rigid rules, to reduce anxiety or to achieve a sense of "completeness". Obsessive-compulsive disorder can also be distinguished from autism spectrum disorder because difficulties in initiating and sustaining social communication and reciprocal social interactions are not features of obsessive-compulsive disorder.

Boundary with stereotyped movement disorder

Stereotyped movement disorder is characterized by the persistent (e.g. lasting for several months) presence of voluntary, repetitive, stereotyped, apparently purposeless and often rhythmic movements (e.g. body rocking, hand flapping, head banging, eye poking and hand biting). These movements are typically less complex than compulsions, and are not aimed at neutralizing obsessions.

Boundary with delusional disorder and other primary psychotic disorders

Some individuals with obsessive-compulsive disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that their conviction of the veracity of their obsessions – and the strength of beliefs regarding the connection between compulsions and obsessions – may at times appear to be delusional in the degree of conviction and fixity with which these beliefs are held (see insight specifiers, p. 301). If these beliefs are restricted to fear or conviction that intrusive thoughts, images or impulses/urges are true, or that compulsions are realistically connected to obsessional content in an individual without a history of other delusions – that is, these beliefs occur entirely in the context of symptomatic episodes of obsessive-compulsive disorder and are fully consistent with the other clinical features of the disorder – obsessive-compulsive disorder should be diagnosed instead of delusional disorder. Individuals with obsessive-compulsive disorder do not exhibit other features of psychosis (e.g. hallucinations or formal thought disorder).

Boundary with depressive disorders

Differentiating rumination that occurs in the context of depressive disorders from obsessions and compulsive mental acts characteristic of obsessive-compulsive disorder is challenging. Nonetheless, it may be helpful to consider that ruminations are typically congruent with negative affect and reflect depressive cognition (e.g. self-criticism, guilt, failure, regret, pessimism, hopelessness). Unlike obsessions, ruminations are not typically experienced as intrusive; nor are they linked to compulsive behaviours. In contrast to ruminations, compulsive mental acts are typically performed with the intention of reducing distress or perceived risk of harm. Individuals with depressive disorders experience low mood or a lack of interest in pleasurable activities, which are not diagnostic features of obsessive-compulsive disorder. However, obsessive-compulsive disorder and depressive disorders often co-occur, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with anxiety and fear-related disorders

Recurrent thoughts, avoidance behaviours and requests for reassurance commonly observed in obsessive-compulsive disorder also occur in anxiety and fear-related disorders. In contrast to anxiety and fear-related disorders, however, obsessions in obsessive-compulsive disorder are experienced as intrusive, can involve content that is odd or irrational (e.g. intrusive images of harming a friend), and are typically accompanied by compulsions. Obsessive-compulsive disorder is further differentiated by not being characterized by the same foci of apprehension that characterize anxiety and fear-related disorders. For example, in generalized anxiety disorder, the recurrent thoughts or worries are focused on negative events that could possibly occur in different aspects of everyday life (e.g. work, finances, health, family). In social anxiety disorder, symptoms are in response to feared social situations (e.g. speaking in public, initiating a conversation) and concerns about being negatively evaluated by others. In specific phobia, symptoms are limited to one or a few circumscribed phobic objects or situations (e.g. fear and avoidance of animals), and concerns are about the perceived harm that could arise if exposed to these stimuli (e.g. being bitten by an animal).

Boundary with panic disorder

Panic disorder is characterized by recurrent, unexpected panic attacks. Some individuals with obsessive-compulsive disorder experience panic attacks that are triggered by feared stimuli associated with obsessions and compulsions or if the individual is prevented from enacting neutralizing compulsions. If an individual with obsessive-compulsive disorder experiences panic attacks exclusively in relation to obsessions or compulsions without the presence of unexpected panic attacks, an additional diagnosis of panic disorder is not warranted. However, if unexpected panic attacks are also present and all other diagnostic requirements are met, both diagnoses may be assigned.

Boundary with post-traumatic stress disorder

In post-traumatic stress disorder, symptoms are limited to stimuli associated with or that serve as reminders of a traumatic event (e.g. fear and avoidance of a place where an individual was assaulted) and the intrusive thoughts and images are associated with the traumatic event.

Boundary with eating disorders

Obsessive-compulsive disorder can be distinguished from anorexia nervosa, bulimia nervosa and binge-eating disorder because obsessions and compulsions are not limited to concerns about being or becoming overweight, and are not accompanied by body-image distortions.

Boundary with disorders due to substance use and impulse control disorders

A variety of behaviours may be described by lay people and sometimes by health professionals as "compulsive", including sexual behaviour, gambling and substance use. Compulsions characteristic of obsessive-compulsive disorder are differentiated from these behaviours in that they typically lack a rational motivation, and are rarely reported to be pleasurable, although they may reduce anxiety or distress. Behaviours such as sexual behaviour, gambling and substance abuse are also not typically preceded by intrusive unwanted thoughts characteristic of obsessions, although they are often preceded by thoughts about engaging in the relevant behaviour.

Boundary with primary tics and tic disorders including Tourette syndrome

A tic is a sudden, rapid, recurrent, non-rhythmic motor movement or vocalization (e.g. eye blinking, throat clearing). Obsessive-compulsive disorder can be differentiated from tic disorders because, unlike compulsions, tics appear unintentional in nature and clearly utilize a discrete muscle group. However, it can be difficult to distinguish between complex tics and compulsions associated with obsessive-compulsive disorder. Although tics (both complex and simple) are preceded by premonitory sensory urges, which diminish as tics occur, tics are not aimed at neutralizing antecedent cognitions (e.g. obsessions) or reducing anxiety. Many individuals exhibit symptoms of both obsessive-compulsive disorder and primary tic disorders – in particular, Tourette syndrome – and both diagnoses may be assigned if the diagnostic requirements for each are met.

Boundary with personality disorder with prominent anankastic features

Personality disorder with prominent anankastic features involves an enduring and pervasive maladaptive pattern of excessive perfectionism and rigid control. Individuals with personality disorder with prominent anankastic features do not experience intrusive thoughts, images, or impulses/urges characteristic of obsessive-compulsive disorder, or engage in repetitive behaviours response to these intrusive thoughts. If diagnostic requirements for both obsessive-compulsive disorder and a personality disorder with prominent anankastic features are met, both diagnoses may be assigned.

6B21 Body dysmorphic disorder

Essential (required) features

- Persistent preoccupation with one or more perceived defects or flaws in appearance, or ugliness in general, that is either unnoticeable or only slightly noticeable to others, is required for diagnosis.
- The presentation is characterized by excessive self-consciousness about the perceived defects or flaws, often including ideas of self-reference (the conviction that people are taking notice, judging or talking about the perceived defects or flaws).
- The preoccupation or self-consciousness is accompanied by any of the following:
  - repetitive and excessive behaviours, such as repeated examination of the appearance or severity of the perceived defects or flaws (e.g. by checking in reflective surfaces) or comparison of the relevant features with those of others;
  - excessive attempts to camouflage or alter the perceived defects or flaws (e.g. specific and elaborate forms of dress, undergoing ill-advised cosmetic surgical procedures);
  - marked avoidance of social or other situations or stimuli that increase distress about the perceived defects or flaws (e.g. reflective surfaces, changing rooms, swimming pools).
- The symptoms are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight specifiers

Individuals with body dysmorphic disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of some individuals with body dysmorphic disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g. an individual is convinced that others think they are hideously ugly). Insight may vary substantially even over short periods of time – for example, depending on the level of current anxiety or distress – and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g. a few days or a week). The degree of insight that an individual exhibits in the context of body dysmorphic disorder can be specified as follows.

6B21.0 Body dysmorphic disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true, and they are willing to accept an alternative explanation for their experience. This specifier level may still be applied if, at circumscribed times (e.g. when highly anxious), the individual demonstrates no insight.

6B21.1 Body dysmorphic disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true, and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

6B21.Z Body dysmorphic disorder, unspecified

Additional clinical features

- Any part of the body may be the focus of the perceived flaws or defects, but the most common area is the face (especially the skin, nose, hair, eyes, teeth, lips, chin or overall facial appearance). However, there are frequently multiple perceived defects. Usually, the focal feature is regarded as flawed, defective, asymmetrical, too big/small or disproportionate, or the complaint may be of thinning hair, acne, wrinkles, scars, vascular markings, pallor or ruddiness of complexion, or insufficient muscularity. Sometimes the preoccupation is vague or consists of a general perception of ugliness or being "not right" or being too masculine/feminine.
- Muscle dysmorphia, a form of body dysmorphic disorder, can place affected individuals – usually males – at increased risk of complications requiring medical attention (e.g. muscle tears, strains, side-effects of steroid use).
- The risk of suicide in adolescents and adults with body dysmorphic disorder is high, particularly when depressive symptomatology co-occurs. Owing to the low base rate occurrence of attempted and completed suicide, it is difficult to predict suicidal behaviours. Factors to consider in assessing risk include previous attempts, lack of perceived psychosocial support, perception of burdensomeness and hopelessness. It is also important to consider that identification of body dysmorphic disorder may be especially challenging because the increased occurrence of shame and perceived stigma among affected individuals often leads them to conceal their difficulties, or to present with symptoms of depressive disorders, social anxiety disorder or obsessive-compulsive disorder rather than body dysmorphic disorder.
- The diagnosis of body dysmorphic disorder is typically made based on direct observation or physical examination of the perceived body flaws or defects. If this is not possible because it is inappropriate, or the individual refuses to remove their camouflage, then it may be difficult to make a judgement about how noticeable or abnormal a perceived defect

is. In such cases, corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.

- In some cases, individuals may be persistently preoccupied with one or more perceived defects or flaws in appearance, or ugliness in general, of another person – generally a child or a romantic partner – that is either unnoticeable or only slightly noticeable to others. This phenomenon is often referred to as "body dysmorphic disorder by proxy". If the other diagnostic requirements for the disorder are met with reference to the perceived bodily flaws or defects of the other person (e.g. excessive self-consciousness, repetitive and excessive examination or checking, marked camouflaging or alteration of the perceived defect, avoidance of relevant social situations or triggers, distress or functional impairment), a diagnosis of body dysmorphic disorder may be assigned to the individual experiencing the preoccupation.

Boundary with normality (threshold)

- Body-image concerns are common in many cultures, especially during adolescence. Body dysmorphic disorder is differentiated from body dissatisfaction or body-image concerns by the degree of preoccupation and frequency of related recurrent behaviours performed, as well as the degree of distress or interference the individual experiences as a consequence of these symptoms.

Course features

- The onset of body dysmorphic disorder commonly occurs during adolescence, with two thirds of individuals reporting onset before the age of 18 years. Subclinical symptoms may appear during early adolescence (at 12 or 13 years of age).
- Although the typical course of body dysmorphic disorder involves a gradual worsening of symptoms from subclinical to full symptomatic presentation, some individuals may experience an acute onset of symptoms.
- Among individuals with onset before the age of 18 years, body dysmorphic disorder is associated with gradual onset of symptoms and co-occurring disorders. These individuals are also at greater risk of attempting suicide.
- Body dysmorphic disorder is generally considered a chronic disorder.

Developmental presentations

- Notwithstanding a relatively early age of onset of body dysmorphic disorder, it typically takes 10–15 years before affected individuals seek help. New onset may occur among older adults, although research with this age group is very limited.

- Onset of body dysmorphic disorder symptoms tends to be gradual. The disorder is recurrent, chronic and likely to persist without intervention.
- Prevalence of body dysmorphic disorder among adolescents is estimated at approximately 2%, with higher prevalence among females. Prevalence rates are likely an underestimate because shame, embarrassment and stigma about symptoms frequently interfere with help-seeking behaviours.
- Symptom presentation is similar across all age groups. However, differentiating between normality and body dysmorphic disorder in adolescence may be complicated by the emergence of developmentally normative concerns about body image that occur during this stage.
- The course and severity of the disorder tends to be worse among individuals with an earlier onset (prior to the age of 18 years). Specifically, these individuals are at increased risk of suicide, present with more co-occurring mental disorders, have poorer insight, and are more likely to have experienced a gradual progression of symptom onset than individuals who develop body dysmorphic disorder in adulthood. Young people with body dysmorphic disorder are also at increased risk of school dropout, potentially affecting their academic and social development.

Culture-related features

- The symptoms of body dysmorphic disorder are similar across cultures, but specific concerns are shaped by cultural standards regarding what is considered attractive, acceptable, normal or desired. For example, populations in East Asia might be focused on epicanthal folds, and concerns about skin colour may be associated with racialized conceptions of desirable body characteristics.
- Within more collectivistic cultures, or cultures that emphasize shame, the nature of the concern about bodily deformities may be focused on anxiety about causing offence to others.
- Some cultural concepts of distress focus on perceptions of abnormal bodily features and may shape the symptoms of body dysmorphic disorder. For example, the *shubo-kyofu* ("fear of a deformed body") subtype of *taijin kyofusho* has been reported primarily in Japan; it is characterized by intense fear of offending, embarrassing or hurting others through the person's appearance, which is perceived as deformed. Insight is typically poor to absent.

Sex- and/or gender-related features

- Although prevalence rates are similar for both genders, differences in presentation have been described. Women are more likely to experience co-occurring eating disorders, whereas men are more likely to be concerned with the appearance of their genitalia and their overall physique (i.e. muscle dysmorphia).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hypochondriasis (health anxiety disorder)

Hypochondriasis is characterized by persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses, whereas in body dysmorphic disorder the preoccupation is with perceived flaws or defects in the individual's appearance.

Boundary with trichotillomania (hair-pulling disorder) and excoriation (skin-picking) disorder

Hair pulling and skin picking can occur as symptoms of body dysmorphic disorder when there is a preoccupation with the skin or hair appearing defective and the intended aim is to improve its appearance. In contrast, when the behaviour is a body-focused repetitive behaviour with no clear relationship to a perceived defect on the skin or hair, then it is better classified as trichotillomania or excoriation disorder.

Boundary with other obsessive-compulsive and related disorders

Recurrent thoughts and repetitive behaviours occur in other obsessive-compulsive and related disorders, but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In obsessive-compulsive disorder, the intrusive thoughts and repetitive behaviours are not limited to concerns about appearance but rather encompass a variety of obsessions (e.g. of contamination, of causing harm) and compulsions (e.g. excessive washing, counting, checking) intended to neutralize these obsessions. In olfactory reference disorder individuals are preoccupied exclusively with emitting a perceived foul or offensive body odour. However, obsessive-compulsive and related disorders can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.

Boundary with delusional disorder and other primary psychotic disorders

Many individuals with body dysmorphic disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions that their appearance is flawed may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see insight specifiers, p. 308). If these beliefs are restricted to the fear or conviction of having a flawed appearance or bodily defect in an individual without a history of other delusions – that is, these beliefs occur entirely in the context of symptomatic episodes of body dysmorphic disorder and are fully consistent with the other clinical features of the disorder – body dysmorphic disorder should be diagnosed instead of delusional disorder. Individuals with body dysmorphic disorder do not exhibit other features of psychosis (e.g. hallucinations or formal thought disorder).

Boundary with mood disorders

Individuals experiencing a depressive episode with psychotic symptoms may occasionally become preoccupied with perceived physical flaws or defects, which can be differentiated from body dysmorphic disorder on the basis of the absence of such symptoms outside of the mood episode. However, individuals with a history of body dysmorphic disorder commonly experience co-occurring depressive symptoms as a consequence of the distress and impairment of their body dysmorphic disorder symptoms. If depressive symptoms consistent with a mood disorder are present in an individual with body dysmorphic disorder, both disorders may be diagnosed.

Boundary with generalized anxiety disorder

In generalized anxiety disorder, recurrent thoughts or worries are focused on potential negative outcomes that might occur in a variety of everyday aspects of life (e.g. family, finances, work). Although some individuals with generalized anxiety disorder may worry excessively about their appearance, these preoccupations occur together with worries about other aspects of life, are rarely delusional, and are not typically accompanied by the recurrent checking behaviour associated with body dysmorphic disorder.

Boundary with social anxiety disorder

In social anxiety disorder, symptoms are in response to feared social situations, and the primary concern is about the person's own behaviour or manifestations of anxiety (e.g. fear they may blush) being negatively evaluated by others. In contrast, individuals with body dysmorphic disorder believe their appearance or a specific feature of their appearance (e.g. belief that skin appears permanently red) looks flawed. Some individuals with body dysmorphic disorder experience significant anxiety in social situations, and fear they will be seen as ugly and therefore be rejected. If their concerns are broader than the exclusive focus on their perceived flaws or defects in appearance, and other symptoms of social anxiety disorder are present, both conditions may be diagnosed.

Boundary with eating disorders

Body dysmorphic disorder can be distinguished from anorexia nervosa, bulimia nervosa and binge-eating disorder because preoccupations in body dysmorphic disorder are not limited to body-image concerns (i.e. idealized low body weight). Rather, the preoccupations can encompass a variety of idealized aspects of appearance. Some individuals with body dysmorphic disorder exhibit muscle dysmorphia such that they are preoccupied about being insufficiently muscular or lean and, in response, may exhibit unusual eating behaviours (e.g. excessive protein consumption) or engage in excessive exercise (e.g. weight lifting). In these cases, behaviours related to diet and exercise are motivated by a desire to be more muscular rather than to attain or maintain a low body weight. However, if low body weight idealization is central to the clinical presentation, and all other diagnostic requirements are met, a diagnosis of anorexia nervosa instead of body dysmorphic disorder should be assigned.

Boundary with body integrity dysphoria

The persistent preoccupation and excessive self-consciousness experienced by individuals with body dysmorphic disorder derives from their concerns that an aspect of their body or appearance is perceived by others to be ugly or deformed. In contrast, the persistent discomfort or intense negative feelings about a particular body part (most commonly one or both arms or legs) experienced by individuals with the rare condition of body integrity dysphoria derives from their sense that a part of their body is alien, or that the way their body is configured is wrong or unnatural. This leads to a desire to amputate or be rid of the particular body part rather than wishing to improve its appearance.

Boundary with gender incongruence of adolescence and adulthood and gender incongruence of childhood

Gender incongruence of adolescence and adulthood and gender incongruence of childhood differ from body dysmorphic disorder in that in these conditions the preoccupation with aspects of bodily appearance centres exclusively on the individual's experience of a marked incongruence between their expressed or experienced gender and their biological sex. A common consequence is that individuals will clearly state a desire to alter their primary and secondary sex characteristics such that they align with their experienced gender.

6B22 Olfactory reference disorder

Essential (required) features

- Persistent preoccupation about emitting a foul or offensive body odour or breath (i.e. halitosis) that is either unnoticeable or slightly noticeable to others such that the individual's concerns are markedly disproportionate to the smell – if any is perceptible – is required for diagnosis.
- The presentation is characterized by excessive self-consciousness about the perceived odour, often including ideas of self-reference (i.e. the conviction that people are taking notice of, judging or talking about the odour).
- The preoccupation or self-consciousness is accompanied by any of the following:
  - repetitive and excessive behaviours, such as repeatedly checking for body odour or checking the perceived source of the smell (e.g. clothing), or repeatedly seeking reassurance;
  - excessive attempts to camouflage, alter or prevent the perceived odour (e.g. using perfume or deodorant, repetitive bathing, brushing teeth, changing clothing, avoidance of certain foods);
  - marked avoidance of social or other situations or stimuli that increase distress about the perceived foul or offensive odour (e.g. public transportation or other situations of close proximity to other people).
- The symptoms are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight specifiers

Individuals with olfactory reference disorder vary in the degree of insight they have about the accuracy of the beliefs that underlie their symptoms. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of some individuals with olfactory reference disorder may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g. an individual is convinced that they are emitting a foul odour). Insight may vary substantially even over short periods of time – for example, depending on the level of current anxiety or distress – and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g. a few days or a week). The degree of insight that an individual exhibits in the context of olfactory reference disorder can be specified as follows.

6B22.0 Olfactory reference disorder with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true, and they are willing to accept an alternative explanation for their experience. This specifier level may still be applied if, at circumscribed times (e.g. when highly anxious), the individual demonstrates no insight.

6B22.1 Olfactory reference disorder with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true, and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

6B22.Z Olfactory reference disorder, unspecified

Additional clinical features

- The diagnosis of olfactory reference disorder partly depends on determining whether there is evidence of the odour reported by the individual. A variety of other medical and dental conditions can be associated with unpleasant odours (e.g. periodontal disease, trimethylaminuria), and these underlying causes should be ruled out, particularly if the odour is detectable even if slight. However, the perceived odour may vary in intensity, or the individual may be unable or unwilling to remove camouflaging odours (e.g. perfume), which may make it difficult to judge how noticeable the odour is. In such cases, corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.

Boundary with normality (threshold)

- Fear of emitting offensive odours is, to some extent, common in many cultures. However, olfactory reference disorder can be differentiated from normal concerns by the degree of preoccupation and frequency of related recurrent behaviours performed, as well as the degree of distress or interference the individual experiences as a consequence of these symptoms.

Course features

- Onset of olfactory reference disorder is most often reported as occurring during the mid-20s; however, onset during puberty or adolescence is also common.
- Olfactory reference disorder is generally considered a chronic and persistent disorder, with potential worsening over time.
- Embarrassment and shame, in conjunction with limited insight and false beliefs that may be delusional in intensity, may lead to underreporting of concerns related to perceived body odour in clinical settings.
- Individuals with olfactory reference disorders often consult non-mental health services on multiple occasions (e.g. medical, surgical, dental specialists) about their perceived odour prior to receiving a diagnosis.

Culture-related features

- Within more collectivistic cultures, or cultures that emphasize shame, the nature of the concern about bodily odour may be focused around fears of causing offence to others.
- Cultural concepts related to olfactory reference disorder include *taijin kyofusho* in Japan and related conditions in the Republic of Korea and other societies. They are characterized by intense fear of offending, embarrassing or hurting others through improper or awkward social behaviour, movements or appearance. If the concerns focus specifically on body odour, olfactory reference disorder is the appropriate ICD-11 diagnosis. In these cases, insight is typically poor to absent.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with obsessive-compulsive disorder

Recurrent thoughts and repetitive behaviours occur in obsessive-compulsive disorder. However, in olfactory reference disorder, the intrusive thoughts and repetitive behaviours are limited to concerns about body or breath odour. If obsessive thoughts and compulsive behaviours are not restricted to concerns about emitting a smell, both disorders can be diagnosed.

Boundary with delusional disorder and other primary psychotic disorders

Many individuals with olfactory reference disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions that they are emitting a foul odour may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see insight specifiers, p. 314). If these beliefs are restricted to the fear or conviction of emitting a foul odour in an individual without a history of other delusions – that is, these beliefs

occur entirely in the context of symptomatic episodes of olfactory reference disorder and are fully consistent with the other clinical features or the disorder – olfactory reference disorder should be diagnosed instead of delusional disorder. Individuals with olfactory reference disorder do not exhibit other features of psychosis (e.g. hallucinations or formal thought disorder).

Boundary with mood disorders

In depressive disorders with psychotic symptoms, somatic delusions related to a perceived odour can occur (e.g. that their flesh is rotting and smells fetid), but typically these are an integral part of a range of preoccupations or delusions (e.g. related to guilt, nihilism, poverty) and occur alongside other depressive symptoms (e.g. loss of interest in pleasurable activities, suicidality, sleep disturbances and weight loss or gain). However, both disorders may co-occur, and both diagnoses may be assigned if warranted.

Boundary with social anxiety disorder

Individuals with olfactory reference disorder may avoid social situations specifically because they believe they are emitting a foul odour. In contrast, in social anxiety disorder, social situations are avoided because the individual is concerned that they will act in a way, or show anxiety symptoms, that will be negatively evaluated by others (i.e. be humiliating, be embarrassing, lead to rejection or be offensive).

6B23 Hypochondriasis (health anxiety disorder)

Essential (required) features

- Persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses is required for diagnosis.
- The preoccupation is accompanied by either:
  - repetitive and excessive health-related behaviours, such as repeatedly checking of the body for evidence of illness, spending inordinate amounts of time searching for information about the feared illness or repeatedly seeking reassurance (e.g. arranging multiple medical consultations); or
  - maladaptive avoidance behaviour related to health (e.g. avoiding medical appointments).
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Insight specifiers

Individuals with hypochondriasis vary in the degree of insight they have about the accuracy of the beliefs that underlie their health concerns. Although many can acknowledge that their thoughts or behaviours are untrue or excessive, some cannot, and the beliefs of a small minority of individuals with hypochondriasis may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g. an individual is convinced that they have a terminal illness). Insight may vary substantially even over short periods of time – for example, depending on the level of current anxiety or distress – and should be assessed with respect to a time period that is sufficient to allow for such fluctuation (e.g. a few days or a week). The degree of insight that an individual exhibits in the context of hypochondriasis can be specified as follows.

6B23.0 Hypochondriasis with fair to good insight

- Much of the time, the individual is able to entertain the possibility that their disorder-specific beliefs may not be true, and they are willing to accept an alternative explanation for their experience. This specifier level may still be applied if, at circumscribed times (e.g. when highly anxious), the individual demonstrates no insight.

6B23.1 Hypochondriasis with poor to absent insight

- Most or all of the time, the individual is convinced that the disorder-specific beliefs are true, and they cannot accept an alternative explanation for their experience. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

6B23.Z Hypochondriasis, unspecified

Additional clinical features

- Individuals with hypochondriasis often make catastrophic misinterpretations of bodily signs or symptoms, including normal or commonplace sensations (e.g. worrying that a tension headache is indicative of a brain tumour).
- Individuals with hypochondriasis typically have a high level of anxiety about health, are often hypervigilant of bodily sensations and symptoms, and may become easily alarmed about their personal health status, to the extent that the experience of anxiety – including panic attacks – may be a significant presenting feature. For this reason, health anxiety disorder is included as an alternative name for the disorder.

- Individuals with hypochondriasis may undergo repeated, unnecessary medical examinations and diagnostic tests, with deterioration of the clinician-individual relationship, and frequent "doctor-shopping". They may also spend excessive time searching health and medical sites on the internet.
- Conversely, individuals with hypochondriasis may respond to their anxiety about their health by avoiding contact with reminders of health status, including medical check-ups, health facilities and health-related information.
- Individuals with hypochondriasis may become alarmed about their health when someone they know becomes sick, when they read or hear about illness, or in response to life stressors. The preoccupation is often a central topic of their conversation with others.

Boundary with normality (threshold)

- The preoccupation is not simply a reasonable concern related to a circumscribed situation (e.g. awaiting results of testing for a serious illness), and persists or reoccurs despite appropriate medical evaluation and reassurance.
- If a chronic or acute medical condition is present, or the individual is at high risk of developing a medical condition (e.g. due to high genetic risk, a recent exposure to a communicable disease), preoccupations related to such conditions are common, and a high threshold should be used for a diagnosis of hypochondriasis. The diagnosis of hypochondriasis should only be made if the degree of preoccupation and repetitive health-related behaviours or avoidance are clearly excessive and disproportionate.
- Health-related anxiety is common among older adults. New onset of health concerns in later life may reflect normal age-related concerns or, if excessive and impairing, the presence of a depressive disorder rather than hypochondriasis.

Course features

- Hypochondriasis is generally considered to be a chronic and relapsing condition leading to significant impairment.
- Individuals with hypochondriasis are much more likely to seek medical services for somatic rather than mental health reasons, which often contributes to health-related anxiety due to the wait for diagnostic testing or the belief that their concerns are not being taken seriously.

Developmental presentations

- Hypochondriasis tends to have its onset in early to mid-adulthood. Identification is often delayed because patients seek multiple consultations with health-care providers, focusing on having a serious physical illness.

- Hypochondriasis is thought to be rare in childhood and adolescence. However, fears and beliefs focusing on health may emerge in early childhood, with significant levels of symptoms persisting throughout childhood, potentially contributing to diagnostic requirements being met in adulthood.
- Hypochondriasis is common among older adults – although often underdiagnosed – with symptoms frequently focusing on memory loss. Clinicians may fail to identify hypochondriasis due to the presence of comorbid medical conditions that emerge with ageing and/or co-occurrence with depressive symptoms that overshadow hypochondriacal concerns. Preoccupations with bodily concerns increases with age such that determining the degree to which these concerns are manifestations of depressive symptoms, physical conditions, an accurate reflection of declining bodily functioning, or hypochondriasis is challenging.
- Among younger children, differential diagnosis between hypochondriasis and obsessive-compulsive disorder is particularly challenging because health concerns can be prominent features of both disorders. Children may not be able to articulate the content of their fears or the focus of their apprehension, making it difficult to assess the difference between symptoms of hypochondriasis and obsessive-compulsive disorder.

Culture-related features

- In hypochondriasis, the focus of illness belief or conviction may be influenced by cultural beliefs about how the illness might have been acquired. For example, in some cultures, hypochondriasis might arise as a result of perceived failure to follow prescribed cultural practices or rituals, or as the effect of a curse, witchcraft or sorcery.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with body dysmorphic disorder

Body dysmorphic disorder is characterized by persistent preoccupation with perceived flaws or defects in the individual's appearance, whereas in hypochondriasis the preoccupation is about the possibility of having one or more serious, progressive or life-threatening illnesses.

Boundary with other obsessive-compulsive and related disorders

Recurrent thoughts and repetitive behaviours occur in other obsessive-compulsive and related disorders, but the foci of apprehension and form of repetitive behaviours are distinct for each diagnostic entity. In obsessive-compulsive disorder, the intrusive thoughts and repetitive behaviours are not limited to concerns about health but rather encompass a variety of obsessions (e.g. of contamination, of causing harm) and compulsions (e.g. excessive washing, counting, checking) intended to neutralize these obsessions. In body dysmorphic disorder, the preoccupation is with perceived flaws in appearance or physical features, whereas in olfactory reference disorder, individuals are preoccupied exclusively with emitting a perceived foul or offensive body odour. However, obsessive-compulsive and related disorders can co-occur, and multiple diagnoses from this grouping may be assigned if warranted.

Boundary with delusional disorder and other primary psychotic disorders

Some individuals with hypochondriasis lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions of having a medical illness may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see insight specifiers, p. 318). If these beliefs are restricted to the fear or conviction of having a disease in an individual without a history of other delusions – that is, these beliefs occur entirely in the context of symptomatic episodes of hypochondriasis and are fully consistent with the other clinical features of the disorder – hypochondriasis should be diagnosed instead of delusional disorder. Somatic delusions characteristic of some presentations of delusional disorder tend to be less medically plausible (e.g. that an organ is rotting), and are generally not focused on the belief that the individual has a specific disease. Individuals with hypochondriasis do not exhibit other features of psychosis (e.g. hallucinations or formal thought disorder).

Boundary with depressive disorders

In depressive disorders, hypochondriacal preoccupations or somatic delusions can occur, but typically they are an integral part of a range of preoccupations or delusions (e.g. related to guilt, nihilism, poverty) and occur alongside other depressive symptoms (e.g. loss of interest in pleasurable activities, suicidality, sleep disturbances and weight loss or gain).

Boundary with generalized anxiety disorder

Individuals with generalized anxiety disorder may have worries about their health, but they also harbour a range of other worries focused on negative events that could occur in several different aspects of everyday life (e.g. work, finances, health, family). Unlike in hypochondriasis, there is typically not a persistent preoccupation with illness that persists despite medical evaluation and reassurance.

Boundary with panic disorder

Panic disorder is characterized by recurrent, unexpected panic attacks. Individuals with panic disorder often worry that the somatic symptoms they experience during panic attacks are evidence of serious medical condition (e.g. a heart attack or a stroke). An additional diagnosis of hypochondriasis should not be assigned on that basis. Conversely, if an individual with hypochondriasis experiences panic attacks exclusively in response to preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses, an additional diagnosis of panic disorder is not warranted. However, if both unexpected panic attacks and persistent preoccupation or fear about the possibility of having one or more serious, progressive or life-threatening illnesses are present and all other diagnostic requirements are met, both diagnoses may be assigned.

Boundary with bodily distress disorder

Bodily distress disorder is characterized by the presence of bodily symptoms that are distressing to the individual and to which excessive attention is directed, such as dwelling on the severity of the symptoms and repeatedly visiting health-care providers. While some individuals with hypochondriasis may experience bodily symptoms that cause distress and for which they may seek medical attention, their main concern in doing so is the fear that the symptoms are indicative of having a serious, progressive or life-threatening illness. In contrast, individuals with bodily distress disorder are typically preoccupied with the bodily symptoms themselves and the impact they have on their lives, and while they may seek out health-care providers who can determine the cause of their symptoms, they do so in order to get relief from the symptoms, not to disconfirm the belief that they have a serious medical illness.

6B24 Hoarding disorder

Essential (required) features

- Accumulation of possessions that results in living spaces becoming cluttered to the point that their use or safety is compromised is required for diagnosis. ***Note:*** if living areas are uncluttered, this is only due to the intervention of third parties (e.g. family members, cleaners, authorities). Accumulation occurs due to both:
  - repetitive urges or behaviours related to amassing items, which may be passive (e.g. accumulation of incoming flyers or mail) or active (e.g. excessive acquisition of free, purchased or stolen items); and
  - difficulty discarding possessions due to a perceived need to save items, and distress associated with discarding them.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Insight specifiers

Individuals with hoarding disorder vary in the degree to which they recognize that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are problematic. For example, some can acknowledge that their living space presents a hazard, that many of the items they save are without value and unlikely to be of future use, or that their distress associated with discarding items is not rational. Others are convinced that their hoarding-related beliefs and behaviours are not problematic, despite evidence to the contrary, and the beliefs of some may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (e.g. an individual insists that items that objectively have little or no value are critically important to save, or denies that there is any problem with their living space). Insight may vary substantially even over short periods of time – for example, depending on the level of current anxiety or distress – such as when a family member or other person forces the individual to discard items. The degree of insight that an individual exhibits in the context of hoarding disorder can be specified as follows.

6B24.0 Hoarding disorder with fair to good insight

- Much of the time, the individual recognizes that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are problematic. This specifier level may still be applied if, at circumscribed times (e.g. when being forced to discard items), the individual demonstrates no insight.

6B24.1 Hoarding disorder with poor to absent insight

- Most or all of the time, the individual is convinced that hoarding-related beliefs and behaviours (pertaining to excessive acquisition, difficulty discarding, or clutter) are not problematic, despite evidence to the contrary. The lack of insight exhibited by the individual does not vary markedly as a function of anxiety level.

6B24.Z Hoarding disorder, unspecified

Additional clinical features

- Assessment for the diagnosis of hoarding disorder may require obtaining additional information beyond self-report, such as reports from collateral informants or visual inspection of clutter in the home.
- Generally, items are hoarded because of their emotional significance (e.g. association with a significant event, person, place or time), instrumental characteristics (e.g. perceived usefulness) or intrinsic value (e.g. perceived aesthetic qualities).
- Individuals with hoarding disorder may be unable to find important items (e.g. bills, tax forms), circulate easily inside their home, or even exit their home in the event of an emergency. Ability to prepare food, use sinks or home appliances (e.g. refrigerator, stove, washing machine) or furniture (e.g. sofas, chairs, beds, tables) may also be compromised.
- Individuals with hoarding disorder may experience a range of chronic medical problems, such as obesity, and are exposed to various environmental risks often caused by their hoarding behaviour, including fire hazards, injuries from falling, contamination by rotting perishable foods, and allergies from contact with dust pollen and bacteria.

Boundary with normality (threshold)

- Collectors acquire many items that they report being attached to and are reluctant to discard. However, they are also more targeted in their acquisitions (e.g. confining their acquisitions to a narrow range of items), more selective (e.g. planning and purchasing only predetermined items), more likely to organize their possessions, and less likely to accumulate items in an excessive manner.

Course features

- Hoarding behaviours often begin during childhood or adolescence, and persist into later life. Onset after the age of 40 years is rare.
- Hoarding disorder is typically chronic and progressive.
- The consequences of hoarding typically become more severe and impairing with age, owing to accumulation of objects over time and an increasing inability to discard or organize possessions. Sometimes, this is due to the onset of comorbid medical conditions and co-occurring mental disorders.
- Among older adults, hoarding disorder is associated with impairment in a range of life domains, including unsafe living conditions, social isolation, pathological self-neglect (i.e. poor hygiene), co-occurring mental disorders and medical comorbidities.

Developmental presentations

- Hoarding disorder has its onset in childhood and adolescence (between the ages of 11 and 15 years) with prevalence rates reported as high as 2–3.7% by mid-adolescence. Later life onset may be a manifestation of the cognitive deficits and behavioural symptoms associated with dementia (e.g. decreased inhibition or repetitive behaviour) rather than hoarding disorder.
- Excessive collecting and accumulation of clutter characteristic of hoarding disorder in adults may not be as evident among young people because caregivers may restrict excessive acquisition of objects. As such, hoarding is more likely to be restricted to particular areas (such as a child's bedroom) and types of materials (such as school-related objects, toys and food) that the child can most easily access.
- Collecting and saving items is developmentally appropriate behaviour for young children up to the age of 6 years, making it more challenging for parents and clinicians to differentiate problematic hoarding from age-appropriate collecting and retaining objects.
- Individuals with hoarding disorder are more likely to experience co-occurring mental disorders or comorbid medical conditions, though this varies across developmental periods. Children and adolescents with hoarding symptoms are more likely to have co-occurring mental disorders, such as obsessive-compulsive disorder or attention deficit hyperactivity disorder. Hoarding symptoms are also more common among young people with autism spectrum disorder or Prader-Willi syndrome. However, an additional diagnosis of hoarding disorder may be appropriate if the symptoms of each disorder require independent clinical attention. Among older adults with hoarding disorder, depressive disorders, anxiety and fear-related disorders and post-traumatic stress disorder are the most common co-occurring mental disorders.
- Hoarding occurring later in life has also been correlated with decreased memory, attention and executive functioning, although the increased rates of co-occurring disorders such as dementia and depressive disorders may also be involved.

Culture-related features

- The nature of what is collected and the meaning, emotional valence and value that people with hoarding disorder assign to their possessions may have cultural significance.
- Cultural values of thriftiness and accumulation should not be mistaken as evidence of disorder. In some cultural environments, saving items for later use is encouraged. This may be especially true in contexts of scarcity or within groups who have experienced protracted periods of scarcity. Unless the symptoms are beyond what is expected of the cultural norms, these behaviours should not be assigned a diagnosis of hoarding disorder.

Sex- and/or gender-related features

- Although prevalence rates for hoarding disorder are higher among women in clinical samples, some epidemiological studies have reported significantly higher prevalence rates among men.
- Men with hoarding disorder are more likely to have co-occurring obsessive-compulsive disorder.
- Although the presenting features of hoarding disorder do not vary across genders, women tend to exhibit more excessive acquisition, particularly by means of compulsive buying.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with obsessive-compulsive disorder

Individuals affected by obsessive-compulsive disorder may accumulate excessive amounts of objects (i.e. compulsive hoarding). However, unlike hoarding disorder, the behaviour is undertaken with the goal of neutralizing or reducing concomitant distress and anxiety arising from obsessional content such as aggressive (e.g. fear of harming others), sexual/religious (e.g. fear of committing blasphemous or disrespectful acts), contamination (e.g. fear of spreading infectious diseases) or symmetry/ordering (e.g. feeling of incompleteness) themes. Furthermore, even in individuals affected by obsessive-compulsive disorder who have poor or absent insight, the behaviour is generally unwanted and distressing, whereas in hoarding disorder it may be associated with pleasure or enjoyment. However, both diagnoses may be assigned if the diagnostic requirements for each are met.

Boundary with autism spectrum disorder

Autism spectrum disorder is characterized by restricted interests that may result in object accumulation, and may also result in difficulty discarding objects due to distress associated with changes imposed on a familiar environment. However, individuals with autism spectrum disorder display other symptoms that are typically lacking among individuals with hoarding disorder, including persistent deficits in social communication and reciprocal social interactions.

Boundary with delusional disorder and other primary psychotic disorders

In schizophrenia and other primary psychotic disorders, object accumulation may occur but is typically driven by delusions. Some individuals with hoarding disorder lack insight about the irrationality of their thoughts and behaviours to such an extent that convictions of the importance of acquiring and retaining items may at times appear to be delusional in the degree of conviction or fixity with which these beliefs are held (see insight specifiers, p. 322). If these beliefs are restricted to the fear of discarding items or conviction that items have a special importance despite objective evidence to the contrary without a history of other delusions – that is, these beliefs occur entirely in the context of symptomatic episodes of hoarding disorder and are fully consistent with the other clinical features of the disorder – hoarding disorder should be diagnosed instead of delusional disorder. Individuals with hoarding disorder do not exhibit other features of psychosis (e.g. hallucinations or formal thought disorder).

Boundary with mood disorders

Unlike individuals with hoarding disorder, those with mood disorders may exhibit hoarding secondary to depressive or manic symptomatology. In the case of depressive disorders, decreased energy, lack of initiative or apathy may lead to object accumulation, which – unlike hoarding disorder – is done without any intention or purpose. Furthermore, individuals with depressive disorders may be indifferent to hoarding objects, and display no distress associated with discarding them. In the case of bipolar disorders, object accumulation may be secondary to excessive buying that can occur during manic episodes. However, those with bipolar disorders do not have difficulty discarding or parting with possessions, and only very rarely are manic episodes of sufficient duration to allow for a substantial amount of clutter to develop in the home.

Boundary with feeding and eating disorders

Some individuals diagnosed with feeding and eating disorders may accumulate large quantities of food to allow for binge eating in specific situations (e.g. while at home alone). However, in contrast to hoarding disorder, the purpose of accumulation is restricted to the consumption of food. Concerns about being or becoming overweight and body-image distortions are not present in hoarding disorder.

Boundary with dementia

Some individuals with dementia accumulate objects as a result of progressive neurocognitive deficit. Unlike hoarding disorder, individuals with dementia display little interest in accumulating objects or distress associated with discarding items. Furthermore, collecting behaviour in dementia may be accompanied by severe personality and behavioural changes, such as apathy, sexual indiscretions and motor stereotyped movements.

Boundary with Prader-Willi syndrome

Prader-Willi syndrome is associated with an increased drive to eat and a range of compulsive symptoms, including food storing. The presence of short stature, hypogonadism, failure to thrive, hypotonia and a history of feeding difficulty in the neonatal period are helpful for the differential diagnosis with hoarding disorder.

6B25 Body-focused repetitive behaviour disorders

Body-focused repetitive behaviour disorders are characterized by recurrent and habitual actions directed at the integument (e.g. hair pulling, skin picking, lip biting), typically accompanied by unsuccessful attempts to decrease or stop the behaviour involved, and which lead to dermatological sequelae (e.g. hair loss, skin lesions, lip abrasions). The behaviour may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods.

General cultural considerations for body-focused repetitive behaviour disorders

- People who may inflict bodily harm to themselves (e.g. self-flagellation or self-cutting) as a part of religious ceremonies should not be assigned this diagnosis.

6B25.0 Trichotillomania (hair-pulling disorder)

Essential (required) features

- The presentation is characterized by:
  - recurrent pulling of the individual's hair;
  - unsuccessful attempts to stop or decrease hair pulling;
  - significant hair loss results from pulling behaviour.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional clinical features

- Hair pulling may occur from any region of the body where hair grows. However, the most common sites are the scalp, eyebrows and eyelids. Less frequently reported sites are axillary, facial, pubic and peri-rectal regions. Patterns of hair loss are variable, with some areas of complete alopecia and others with thinning hair density.
- Individuals with trichotillomania may pull hair in a widely distributed pattern (i.e. pulling single hairs from all over a site) such that hair loss may not be clearly visible. Alternately, individuals may attempt to conceal or camouflage hair loss (e.g. by using makeup, scarves or wigs).

- The diagnosis of trichotillomania is typically made based on direct observation or physical examination of the hair loss. If this is not possible (e.g. because of religious proscriptions), then it may be difficult to make a judgement about the extent of hair loss. In such cases, corroborative evidence may be required from a knowledgeable informant or physician who has conducted a physical examination of the individual.
- Hair pulling may occur in brief episodes scattered throughout the day or in less frequent but more sustained periods that can continue for hours. Hair pulling may endure for months or years before coming to clinical attention.
- Trichotillomania often presents with rituals surrounding hair such as visually or tactilely examining the hair or orally manipulating the hair after it has been pulled. Individuals who commonly swallow or eat the hair that has been pulled (trichophagia) can experience serious and even life-threatening gastrointestinal symptoms, depending on the volume of hair consumed.
- Focused hair pulling often increases during periods of increased psychological distress.
- Hair-pulling behaviour is associated with a variety of reported effects, including regulation of affect and arousal, tension reduction and promotion of pleasure, which presumably reinforce these behaviours. However, in the aftermath of hair pulling, many individuals report a variety of negative affective states, such as a sense of loss of control or shame. Individuals with trichotillomania report varying degrees of awareness of their hair-pulling behaviour.
- Trichotillomania commonly co-occurs with excoriation disorder, other body-focused repetitive behaviours (e.g. nail biting), obsessive-compulsive disorder, depressive disorders, and anxiety and fear-related disorders.

Boundary with normality (threshold)

- Occasional pulling of a grey or out-of-place hair is normal and done by most people at some time in their lives. Many individuals also twist and play with their hair, whereas others may bite or tear rather than pull their hair; these behaviours do not qualify for a diagnosis of trichotillomania. Trichotillomania involves recurrent hair pulling, and is associated with significant distress or impairment, which are not present in occasional, normal pulling.

Course features

- Trichotillomania is generally considered a chronic condition; however, for some individuals, symptoms may wax and wane for weeks, months or years at a time without intervention. Rates of remission decrease with increasing time since symptom onset.
- Patterns of hair-pulling behaviour vary greatly, and individual sites of hair pulling may change over time.

Developmental presentations

- Onset of trichotillomania is bimodal, with a peak during early childhood and one during early adolescence.
- Hair-pulling behaviour in infancy (before 2 years of age) is relatively common, with most individuals ceasing to engage in the behaviour by early childhood. However, many adults reporting a chronic history of trichotillomania describe early childhood onset. Whether onset in early childhood (compared to onset in adolescence) presents as a distinct subtype of the disorder, or what factors may contribute to persistence, is therefore unknown.
- Onset is most common in early adolescence, coinciding with puberty. Adolescent onset is associated with greater chronicity and impairment. Prevalence rates among adolescents are similar to those among adults (approximately 1–2% of the general population).
- Children and adolescents engage more frequently in automatic hair pulling; that is, they engage in the behaviour outside awareness. Focused, intentional hair pulling – often preceded by intense urges and followed by relief – is more common among adolescents and adults.
- The negative impact of hair pulling appears to become more severe across developmental periods. Children under the age of 10 years appear to experience less academic impact than older children and adolescents, who tend to report more difficulties in school attendance and academic performance as a result of hair pulling.
- As with adults, children and adolescents with trichotillomania appear to have high rates of co-occurring mental health disorders, including generalized anxiety disorder, obsessive-compulsive disorder, excoriation (skin-picking) disorder, other body-focused repetitive behaviour disorders and depressive disorders. Children and adolescents may also be more likely to present with co-occurring attention deficit hyperactivity disorder.

Sex- and/or gender-related features

- Prevalence rates appear to be equal among girls and boys in childhood, although female adolescents and adults are more commonly diagnosed.
- Although there is no evidence for gender differences in course and symptom presentation, men are more likely to experience a co-occurring anxiety or fear-related disorder or obsessive-compulsive disorder.
- Focused hair pulling in women often increases during puberty and at other times of hormonal fluctuations during adulthood (e.g. menstruation, perimenopause).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with other obsessive-compulsive and related disorders

Repetitive behaviours observed in trichotillomania occur in other obsessive-compulsive and related disorders, but these are typically related to specific foci of apprehension, and are associated with distinct intent for each diagnostic entity. Individuals diagnosed with obsessive-compulsive disorder may engage in hair-pulling behaviour (e.g. as a symmetry ritual meant to "balance" their hair). Furthermore, individuals with obsessive-compulsive disorder often exhibit other symmetry rituals alongside identifiable obsessions and compulsions unrelated to hair pulling. Nonetheless, co-occurrence with obsessive-compulsive disorder is common, and if both disorders are present, both may be diagnosed. Body dysmorphic disorder may be associated with removal of body hair that the individual perceives as ugly or as appearing abnormal.

Boundary with stereotyped movement disorder

Stereotyped movement disorder is characterized by the persistent (e.g. lasting for several months) presence of voluntary, repetitive, stereotyped, apparently purposeless and often rhythmic movements (e.g. body rocking, hand flapping, head banging, eye poking and hand biting). These behaviours rarely include hair-pulling behaviour, but if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable. Furthermore, stereotyped movements are more likely to present very early in life (i.e. before 2 years of age), whereas trichotillomania typically has an onset in early adolescence.

Boundary with schizophrenia and other primary psychotic disorders

Individuals with schizophrenia and other primary psychotic disorders may remove hair in response to a delusion or hallucination. An additional diagnosis of trichotillomania should not be assigned in such cases.

Boundary with medical conditions classified elsewhere and disorders due to substance use

The symptoms of trichotillomania are not a manifestation of another medical condition (e.g. inflammation of the hair follicles). Skin biopsy or dermoscopy are able to differentiate individuals with trichotillomania from those with dermatological disorders. Although hair-pulling behaviour may be exacerbated by certain substances (e.g. amfetamine), there is no evidence that substances can be the primary cause of recurrent hair pulling.

6B25.1 Excoriation (skin-picking) disorder

Essential (required) features

- The presentation is characterized by:
  - recurrent picking of the individual's skin;
  - unsuccessful attempts to stop or decrease skin picking;
  - significant skin lesions resulting from picking behaviour.

- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional clinical features

- Furthermore, excoriation disorder commonly co-occurs with depressive and anxiety symptoms, obsessive-compulsive disorder and other body-focused repetitive behaviours (e.g. nail biting).
- The most commonly picked sites are the face, arms and hands, but many individuals pick from multiple body sites. Individuals may pick at healthy skin, at minor skin irregularities, at lesions such as pimples or calluses, or at scabs from previous picking. Most individuals pick with their fingernails, although a substantial minority use tweezers, knives or other objects. The essential features emphasize that skin picking must lead to skin lesions. However, individuals with this disorder often attempt to conceal or camouflage evidence of skin picking (e.g. using makeup or clothing). Therefore, careful assessment including information from collateral sources may be required to ascertain the presence of excoriation disorder symptomatology.
- Individuals with excoriation disorder often spend significant amounts of time on their behaviour – sometimes several hours each day. Skin picking may endure for months or years before coming to clinical attention.
- Excoriation disorder often presents with rituals surrounding the skin such as visually or tactilely examining the skin, orally manipulating or eating the skin or scab after it has been picked.
- Skin-picking behaviour is associated with a variety of reported effects, including regulation of affect and arousal, tension reduction and promotion of pleasure, which presumably reinforce these behaviours. However, in the aftermath of skin picking, many individuals report a variety of negative affective states, such as a sense of loss of control or shame. Individuals with excoriation disorder report varying degrees of awareness of their skin-picking behaviour.
- Excoriation disorder commonly co-occurs with trichotillomania.

Boundary with normality (threshold)

- Occasional picking of one's skin (e.g. scabs, cuticles or acne) is normal and done by most people at some time in their lives. Some individuals bite their cuticles or surrounding skin; these behaviours do not qualify for a diagnosis of excoriation (skin-picking) disorder. Excoriation disorder involves recurrent picking and is associated with significant distress or impairment, which are not present in occasional, normal skin picking.

Course features

- Onset of excoriation disorder can occur at any age, but most often coincides with onset or shortly after onset of puberty.
- The onset commonly occurs in association with a dermatological condition, but the skin picking persists after the dermatological condition resolves.
- For some individuals, an urge to pick at their skin may be preceded by emotional triggers such as increasing feelings of anxiety and tension or boredom. Others may pick at their skin in response to tactile sensitivity (i.e. skin irregularities) or bothersome skin sensations. In such cases, skin picking often results in an alleviation of tension, relief or a sense of gratification.
- Excoriation disorder is generally considered a chronic condition. Some individuals may experience a waxing and waning of symptoms over weeks, months or years at a time.

Developmental presentations

- Excoriation disorder most often has its onset during adolescence, typically corresponding to puberty. However, the emergence of symptoms can occur across the lifespan.
- Childhood-onset excoriation disorder is more prevalent among females.
- Automatic skin picking, which tends to occur unintentionally, outside awareness, appears more frequently among individuals with childhood-onset excoriation disorder. Skin picking then appears to shift in adolescence and adulthood, as picking becomes focused. This picking appears to be generally intentional, connected to intense urges to pick, and often results in a sense of relief.

Sex- and/or gender-related features

- Prevalence rates for excoriation disorder are significantly higher among women.
- Men have an earlier age of onset for the disorder.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with other obsessive-compulsive and related disorders

Repetitive behaviours observed in excoriation disorder occur in other obsessive-compulsive and related disorders, but these are typically related to specific foci of apprehension, and are

associated with distinct intent for each diagnostic entity. Individuals diagnosed with obsessive-compulsive disorder may engage in skin-picking behaviour (e.g. when they experience contamination obsessions that are associated with behaviours intended to pick the skin to remove contamination). Obsessions do not precede skin picking in excoriation disorder, and individuals with obsessive-compulsive disorder often exhibit other compulsions that are unrelated to skin picking. Nonetheless, co-occurrence with obsessive-compulsive disorder is common, and both disorders may be diagnosed if warranted. Body dysmorphic disorder may be associated with picking as a means of improving the individual's appearance by "removing" acne or other perceived blemishes of the skin that the individual believes are ugly or that appear abnormal. Individuals with excoriation disorder do not pick skin with the sole purpose of correcting a perceived defect in appearance.

Boundary with stereotyped movement disorder

Stereotyped movement disorder is characterized by the persistent (e.g. lasting for several months) presence of voluntary, repetitive, stereotyped, apparently purposeless and often rhythmic movements (e.g. body rocking, hand flapping, head banging, eye poking and hand biting). These behaviours rarely include skin-picking behaviour, but if they do, the behaviour tends to be composed of coordinated movements that are patterned and predictable. Furthermore, stereotyped movements are more likely to present very early in life (i.e. before 2 years of age), whereas excoriation disorder typically has a later onset.

Boundary with schizophrenia and other primary psychotic disorders

Individuals with schizophrenia and other primary psychotic disorders may pick at their skin in response to a delusion or hallucination. Individuals with excoriation disorder do not report skin picking secondary to delusions or hallucinations.

Boundary with Prader-Willi syndrome

Individuals with Prader-Willi syndrome may have early onset of skin picking more consistent with a stereotyped movement disorder. Prader-Willi syndrome is usually associated with a constellation of other symptoms, such as mild to moderate disorder of intellectual development, neonatal and infantile hypotonia, feeding problems and poor weight gain in infancy, followed by hyperphagia and morbid obesity in childhood.

Boundary with medical conditions classified elsewhere and disorders due to substance use

The symptoms of excoriation disorder are not a manifestation of another medical condition (e.g. scabies). However, skin picking may emerge following or be worsened by the presence of another condition (e.g. acne), and a diagnosis of excoriation disorder may be applied in this circumstance if diagnostic requirements are met. Skin picking may also result from the use or misuse of stimulants (e.g. cocaine, methamfetamine, prescription stimulants), but excoriation disorder should not be diagnosed if the skin picking occurs exclusively in this context.

Boundary with self-injurious and self-mutilating behaviours

Unlike self-injurious and self-mutilating behaviours, skin-picking behaviours characteristic of excoriation disorder are not performed with the express purpose of self-injury, although such injury may occur as a result.

6B25.Y Other specified body-focused repetitive behaviour disorder

Essential (required) features

- Recurrent habitual actions directed at the integument other than hair pulling or skin picking (e.g. lip biting or nail biting) are required for diagnosis.
- The presentation is characterized by unsuccessful attempts to stop or decrease the behaviour.
- Significant lesions or other impacts on appearance result from the behaviour.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6B25.Z Body-focused repetitive behaviour disorder, unspecified

6B2Y Other specified obsessive-compulsive or related disorder

Essential (required) features

- The presentation is characterized by symptoms that share primary clinical features with other obsessive-compulsive and related disorders (e.g. obsessions, intrusive thoughts and preoccupations; compulsions, recurrent and habitual actions directed at the integument).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the obsessive-compulsive and related disorders grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a primary psychotic disorder, an impulse control disorder, an anxiety or fear-related disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6B2Z Obsessive-compulsive or related disorder, unspecified

Secondary-parented category in obsessive-compulsive and related disorders

Tourette syndrome, classified in the grouping primary tics and tic disorders in Chapter 8 on diseases of the nervous system, is cross-listed in this grouping because of its high co-occurrence, familial association and analogous phenomenology (i.e. premonitory urges and repetitive behaviours) with obsessive-compulsive disorder. Tourette syndrome, along with chronic motor tic disorder and chronic phonic tic disorder, is also cross-listed in the grouping of neurodevelopmental disorders because of its frequent onset during the developmental period, and high co-occurrence and familial association with neurodevelopmental disorders. The full CDDR for these disorders are provided in the section on secondary-parented categories in neurodevelopmental disorders.

8A05.00 Tourette syndrome

(See p. 154 for the full CDDR.)

Disorders specifically associated with stress

Disorders specifically associated with stress are directly related to exposure to a stressful or traumatic event, or to a series of such events or adverse experiences. For each of the disorders in this grouping, an identifiable stressor is a necessary, though not sufficient, causal factor. Most people who experience stressors do not develop a disorder. Stressful events for some disorders in this grouping are within the normal range of life experiences (e.g. divorce, socioeconomic problems, bereavement). Other disorders require exposure to a stressor that is extremely threatening or horrific in nature (i.e. potentially traumatic events). With all disorders in this grouping, it is the nature, pattern and duration of the symptoms that arise in response to the stressful events – together with associated functional impairment – that distinguishes the disorders.

Disorders specifically associated with stress include the following:

6B40 Post-traumatic stress disorder

6B41 Complex post-traumatic stress disorder

6B42 Prolonged grief disorder

6B43 Adjustment disorder

6B44 Reactive attachment disorder

6B45 Disinhibited social engagement disorder

6B4Y Other specified disorder specifically associated with stress

6B4Z Disorder specifically associated with stress, unspecified.

The categories in the grouping of disorders specifically associated with stress should not be used to classify normal responses to recent stressful or traumatic events.

To assist in differential diagnosis, also listed here is:

QE84 Acute stress reaction

Normal responses to recent traumatic events may be classifiable under acute stress reaction. Acute stress reaction is not considered to be a mental disorder but rather appears in Chapter 24 on factors influencing health status or contact with health services.

General cultural considerations for disorders specifically associated with stress

- Culturally sanctioned and recognized concepts and means of expressing distress – such as local idioms of distress, explanations and syndromes – may be a prominent part of the trauma response. Examples of these cultural concepts include possession states in many cultural groups, *susto* or *espanto* (fright) among Latin American populations, *ohkumlang* (tiredness) and bodily pain among Bhutanese refugees who have survived torture, *ihahamuka* (lungs without breath) among Rwandan genocide survivors, and *kit chraen* (thinking too much) among Cambodians, among others. The symptoms of disorders specifically associated with stress may be described in terms of emotional, cognitive, behavioural and somatic elements of these cultural concepts. Idioms of distress may also influence the symptomatology and co-occurrence of other mental disorders.
- Individuals from collectivistic cultures may focus their concern on family and community relationships rather than personal reactions to trauma. The clinical presentation may include guilt or shame about perceived failures to assist others or fulfil culturally important social roles. For example, survivors of sexual violence may be preoccupied with the shame their family may incur because of the event.
- Across cultures, traumatic events may be attributed to a variety of spiritual or supernatural causes, such as karma, fate, envy, witchcraft/sorcery or vengeful spirits. These attributions influence the personal and social impact of stressors and the nature of the individual's response.
- Knowledge of cultural norms is necessary to assess the severity of the trauma response – in particular, whether psychotic symptoms should be considered consistent with certain cultural expressions of the disorder, a manifestation of another mental disorder (e.g. a psychotic disorder) or consistent with normal functioning within that cultural context.
- The traumatic impact of certain exposures may be strongly influenced by cultural interpretations. For example, for some cultural groups, exposure to the destruction of religious and holy sites or sacred artifacts may be more stressful than personal trauma. It is the characteristic syndromic response that determines whether a diagnosis of a particular disorder is appropriate.
- Migrant populations may experience higher levels of distress related to traumatic exposure as a function of concomitant social factors, including poverty, discrimination by the receiving community and acculturative stressors.

6B40 Post-traumatic stress disorder

Essential (required) features

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature is required for diagnosis. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture, sexual violence, terrorism, assault or acute life-threatening illness (e.g. a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected or violent manner; and learning about the sudden, unexpected or violent death of a loved one.
- Following the traumatic event or situation, the development of a characteristic syndrome lasting for at least several weeks consists of all three of the following core elements.
  - The traumatic event is re-experienced in the present: it is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images; flashbacks, which can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings); or repetitive dreams or nightmares that are thematically related to the traumatic event. Re-experiencing is typically accompanied by strong or overwhelming emotions, such as fear or horror, and strong physical sensations. Re-experiencing in the present can also involve feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event, without a prominent cognitive aspect, and may occur in response to reminders of the event. Reflecting on or ruminating about the event and remembering the feelings experienced at that time are not sufficient to meet the re-experiencing requirement.
  - Reminders likely to produce re-experiencing of the traumatic event are deliberately avoided. Deliberate avoidance may take the form either of active internal avoidance of thoughts and memories related to the event, or external avoidance of people, conversations, activities or situations reminiscent of the event. In extreme cases, the person may change their environment (e.g. move to a different city or change jobs) to avoid reminders.
  - There are persistent perceptions of heightened current threat – for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant people constantly guard themselves against danger, and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g. not sitting with their back to the door, repeatedly checking in vehicles' rear-view mirrors).
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Common symptomatic presentations of post-traumatic stress disorder may also include general dysphoria, dissociative symptoms, somatic complaints, suicidal ideation and behaviour, social withdrawal, excessive alcohol or drug use to avoid re-experiencing or manage emotional reactions, anxiety symptoms including panic, and obsessions or compulsions in response to memories or reminders of the trauma.
- The emotional experience of individuals with post-traumatic stress disorder commonly includes anger, shame, sadness, humiliation or guilt, including survivor guilt.

Boundary with normality (threshold)

- A history of exposure to an event or situation of an extremely threatening or horrific nature does not in itself indicate the presence of post-traumatic stress disorder. Many people experience such stressors without developing a disorder. Rather, the presentation must meet all diagnostic requirements for the disorder.

Course features

- Onset of post-traumatic stress disorder can occur at any time during the lifespan following exposure to a traumatic event.
- Onset of post-traumatic stress disorder symptoms typically occurs within 3 months following exposure to a traumatic event. However, delays in the expression of post-traumatic stress disorder symptomology can occur even years after exposure to a traumatic event.
- The symptoms and course of post-traumatic stress disorder can vary significantly over time and among individuals. Recurrence of symptoms may occur after to exposure to reminders of the traumatic event or as a result of experiencing additional life stressors or traumatic events. Some individuals diagnosed with post-traumatic stress disorder can experience persistent symptoms for months or years without reprieve.
- Nearly half of individuals diagnosed with post-traumatic stress disorder will experience complete recovery of symptoms within 3 months of onset.

Developmental presentations

- Post-traumatic stress disorder can occur at all ages, but responses to a traumatic event – that is, the core elements of the characteristic syndrome – can manifest differently depending on age and developmental stage.
- Emerging cognitive capacities and limited verbal abilities for self-reporting in young children (e.g. under 6 years of age) make it more difficult to assess for the presence of re-experiencing, active avoidance of internal states and perceptions of heightened current threat. Assessments of symptoms should not be based exclusively on child-reported internal symptoms, but should include caregiver reports of observable behavioural symptoms emerging after traumatic experiences.
- In younger children, evidence of the core symptoms supporting a diagnosis of post-traumatic stress disorder often manifests behaviourally, such as in trauma-specific re-enactments that may occur during repetitive play or in drawings, frightening dreams without clear content or night terrors, or uncharacteristic impulsivity. However, children may not necessarily appear distressed when talking about or playing out their traumatic recollections, despite substantial impact on psychosocial functioning and development. Other manifestations of post-traumatic stress disorder in preschool-aged children may be less trauma-specific and include both inhibited and disinhibited behaviours. For example, hypervigilance may manifest as increased frequency and intensity of temper tantrums, separation anxiety, regression in skills (e.g. verbal skills, toileting), exaggerated age-associated fears or excessive crying. External avoidance or expressions of recollection of traumatic experiences may be evidenced by a new onset of acting out, protective or rescue strategies, limited exploration or reluctance to engage in new activities, and excessive reassurance-seeking from a trusted caregiver.
- Limited capacity to reflect on and report internal states may also be characteristic of some school-aged children and adolescents. Furthermore, children and adolescents may be more reluctant than adults to report their reactions to traumatic events. In such cases, greater reliance on changes in behaviour such as increased trauma-specific re-enactments or overt avoidance may be necessary.
- Children or adolescents may deny feelings of distress or horror associated with re-experiencing, and rather report no affect or other types of strong or overwhelming emotions as a part of re-experiencing, including those that are non-distressing.
- In adolescence, reluctance to pursue developmental opportunities (e.g. to gain autonomy from caregivers) may be a sign of psychosocial impairment. Self-injurious or risky behaviours (e.g. substance use or unprotected sex) occur at elevated rates among adolescents and adults with post-traumatic stress disorder.
- Assessment can be complicated in children and adolescents when loss of a parent or caregiver is associated with a traumatic event or an intervention. For example, a chronically abused child who is removed from the home may place greater emphasis on the loss of a primary caregiver than on aspects of the experience that might objectively be considered more threatening or horrific.
- Among older adults with post-traumatic stress disorder, symptom severity may decline over the life-course – especially re-experiencing. However, avoidance of situations, people, activities or conversations about the event, as well as hypervigilance, typically persist. Older people may dismiss their symptoms as a normal part of life, which may be related to shame and fear of stigma.

Culture-related features

- The salience of particular post-traumatic stress disorder symptoms may vary across cultures. For example, in some groups anger may be the most prominent symptom related to traumatic exposure, and the most culturally appropriate way of expressing distress. In other cultural contexts, nightmares may have elaborate cultural significance that increases their importance in assessing for the characteristic symptoms of post-traumatic stress disorder.
- Symptoms central to post-traumatic stress disorder in some cultures may not be included in descriptions of the disorder, and may therefore be missed by clinicians unfamiliar with those cultural expressions. For example, somatic symptoms such as headaches (often with visual aura), dizziness, bodily heat, shortness of breath, gastrointestinal distress, trembling and orthostatic hypotension may be prominent.
- Cultural variation may affect post-traumatic stress disorder onset and the meaning of traumatic stressors. For example, some cultural groups attribute greater risk of post-traumatic stress disorder to traumatic events affecting family members than those affecting the person themselves; other societies may find it particularly traumatic to observe the desecration or destruction of religious symbols or to be denied the ability to perform funeral rites for deceased relatives.
- Certain trauma-related symptoms may be associated with intense fear in particular cultural contexts owing to their connection with specific catastrophic cognitions, and may precipitate panic attacks in the context of post-traumatic stress disorder. These catastrophic interpretations may affect the trajectory of the disorder, and may be associated with greater severity, chronicity or poorer response to treatment. For example, some Latin American patients may consider trauma-related trembling to be the precursor of a lifelong condition of severe *nervios* (nerves), and some Cambodians may interpret palpitations as signs of a "weak heart".
- Some post-traumatic stress disorder symptoms may not be viewed as pathological in some cultural groups. For example, intrusive thoughts may be considered normal rather than a symptom indicating illness. It is important to evaluate the presence of all required diagnostic elements, including functional impairment, rather than treating any one symptom as pathognomic.

Sex- and/or gender-related features

- Post-traumatic stress disorder is more common among females.
- Females diagnosed with post-traumatic stress disorder are more likely to experience a longer duration of impairment and higher levels of negative emotionality and somatic symptoms as a part of their clinical presentation.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with complex post-traumatic stress disorder

Whereas the diagnostic requirements for complex post-traumatic stress disorder include all essential features of post-traumatic stress disorder, the diagnosis of complex post-traumatic stress disorder also requires the additional essential features of severe problems in affect regulation, persistent negative beliefs about oneself, and persistent difficulties in sustaining relationships.

Boundary with prolonged grief disorder

As with post-traumatic stress disorder, prolonged grief disorder may occur in individuals who experience bereavement as a result of the death of a loved one occurring in traumatic circumstances. In post-traumatic stress disorder the individual re-experiences the event or situation associated with the death, while in prolonged grief disorder the person may be preoccupied with memories of the circumstances surrounding the death but, unlike in post-traumatic stress disorder, does not re-experience them as occurring again in the here and now.

Boundary with adjustment disorder

In adjustment disorder, the stressor can be of any severity or any type, and is not necessarily of an extremely threatening or horrific nature. A response to a less serious event or situation that otherwise meets the symptom requirements for post-traumatic stress disorder but that is beyond the duration appropriate for acute stress reaction should be diagnosed as adjustment disorder. Moreover, many people who experience an extremely threatening or horrific event develop symptoms that do not meet the full diagnostic requirements for post-traumatic stress disorder; these reactions are generally better diagnosed as adjustment disorder.

Boundary with acute stress reaction

Normal acute reactions to traumatic events can include all the symptoms of post-traumatic stress disorder, including re-experiencing, but these begin to subside fairly quickly (e.g. within 1 week after the event terminates or after removal from the threatening situation, or within 1 month in the case of ongoing stressors). If clinical intervention is warranted in these situations, a diagnosis of acute stress reaction from Chapter 24 on factors influencing health status or contact with health services (i.e. a non-disorder category) is generally most appropriate.

Boundary with schizophrenia and other primary psychotic disorders

Some individuals with post-traumatic stress disorder re-experience traumatic events in the form of severe flashbacks that may have a hallucinatory quality, or are hypervigilant to threat to the extent that they may appear to be paranoid. Auditory pseudo-hallucinations, recognized as being the person's own thoughts and of internal origin, can occur in post-traumatic stress disorder. Such symptoms should not be considered evidence of a psychotic disorder.

Boundary with depressive episode

In a depressive episode, intrusive memories are not experienced as occurring again in the present, but as belonging to the past, and they are often accompanied by rumination. However, depressive episodes commonly co-occur with post-traumatic stress disorder, and an additional mood disorder diagnosis should be assigned if warranted.

Boundary with panic disorder

In post-traumatic stress disorder, panic attacks can be triggered by reminders of the traumatic event or in the context of re-experiencing. Panic attacks that occur entirely in these contexts do not warrant an additional, separate diagnosis of panic disorder. Instead, the *with panic attacks* specifier (MB23.H) may be applied together with the post-traumatic stress disorder diagnosis. However, if unexpected panic attacks (i.e. those that come on "out of the blue") are also present and the other diagnostic requirements are met, an additional diagnosis of panic disorder is appropriate.

Boundary with specific phobia

In some cases, a situational or conditioned specific phobia can arise after exposure to a traumatic event (e.g. being attacked by a dog). Specific phobia can generally be differentiated from post-traumatic stress disorder by the absence of re-experiencing of the event in the present. Although phobic responses may include powerful memories of the event, in response to which the individual experiences anxiety, the memories are experienced as belonging to the past.

Boundary with dissociative disorders

Following an experience of a traumatic event, a variety of dissociative symptoms can occur, including somatic symptoms, memory disturbances, flashbacks or other trance-like states, alterations in identity and sense of agency, and experiences of depersonalization, especially during the episodes of re-experiencing. If the dissociative symptoms are confined to episodes of re-experiencing in an individual with post-traumatic stress disorder or complex post-traumatic stress disorder, an additional diagnosis of a dissociative disorder should not be assigned. If significant dissociative symptoms are present outside episodes of re-experiencing, and the full diagnostic requirements are met, an additional dissociative disorder diagnosis may be assigned.

Boundary with other mental disorders

It is common for mental disorders other than or in addition to post-traumatic stress disorder to develop in the aftermath of an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature. Thus, a history of exposure to a potentially traumatic event does not in itself indicate the presence of post-traumatic stress disorder. Depressive disorders, anxiety and fear-related disorders, disorders due to substance use, and dissociative disorders can all occur in the aftermath of potentially traumatic experiences, often in the absence of post-traumatic stress disorder.

6B41 Complex post-traumatic stress disorder

Essential (required) features

- Exposure to an event or series of events of an extremely threatening or horrific nature – most commonly prolonged or repetitive events from which escape is difficult or impossible – is required for diagnosis. Such events include, but are not limited to, torture, concentration camps, slavery, genocide campaigns and other forms of organized violence, prolonged domestic violence, and repeated childhood sexual or physical abuse.

- Following the traumatic event, the development of a characteristic syndrome lasting for at least several weeks consists of all three of the following core elements of post-traumatic stress disorder.
  - The traumatic event is re-experienced in the present: it is not just remembered but is experienced as occurring again in the here and now. This typically occurs in the form of vivid intrusive memories or images; flashbacks, which can vary from mild (there is a transient sense of the event occurring again in the present) to severe (there is a complete loss of awareness of present surroundings); or repetitive dreams or nightmares that are thematically related to the traumatic event. Re-experiencing is typically accompanied by strong or overwhelming emotions, such as fear or horror, and strong physical sensations. Re-experiencing in the present can also involve feelings of being overwhelmed or immersed in the same intense emotions that were experienced during the traumatic event, without a prominent cognitive aspect, and may occur in response to reminders of the event. Reflecting on or ruminating about the event and remembering the feelings experienced at that time are not sufficient to meet the re-experiencing requirement.
  - Reminders likely to produce re-experiencing of the traumatic event are deliberately avoided. Deliberate avoidance may take the form either of active internal avoidance of thoughts and memories related to the event, or external avoidance of people, conversations, activities or situations reminiscent of the event. In extreme cases, the person may change their environment (e.g. move house or change jobs) to avoid reminders.
  - There are persistent perceptions of heightened current threat – for example, as indicated by hypervigilance or an enhanced startle reaction to stimuli such as unexpected noises. Hypervigilant people constantly guard themselves against danger, and feel themselves or others close to them to be under immediate threat either in specific situations or more generally. They may adopt new behaviours designed to ensure safety (e.g. not sitting with their back to the door, repeatedly checking in vehicles' rear-view mirrors). In complex post-traumatic stress disorder, unlike in post-traumatic stress disorder, the startle reaction may in some cases be diminished rather than enhanced.

- The presentation is characterized by severe and pervasive problems in affect regulation. Examples include heightened emotional reactivity to minor stressors, violent outbursts, reckless or self-destructive behaviour, dissociative symptoms when under stress, and emotional numbing – particularly the inability to experience pleasure or positive emotions.
- Persistent beliefs about oneself as diminished, defeated or worthless are accompanied by deep and pervasive feelings of shame, guilt or failure related to the stressor. For example, the individual may feel guilty about not having escaped from or succumbing to the adverse circumstance, or not having been able to prevent the suffering of others.
- Persistent difficulties in sustaining relationships and in feeling close to others are present. The individual may consistently avoid, deride or have little interest in relationships and social engagement more generally. Alternatively, there may be occasional intense relationships, but the individual has difficulty sustaining them.
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Suicidal ideation and behaviour, substance abuse, depressive symptoms, psychotic symptoms and somatic complaints may be present.

Boundary with normality (threshold)

- A history of exposure to a stressor of extreme and prolonged or repetitive nature, from which escape is difficult or impossible, does not in itself indicate the presence of complex post-traumatic stress disorder. Many people experience such stressors without developing any disorder. Rather, the presentation must meet all diagnostic requirements for the disorder.

Course features

- The onset of complex post-traumatic stress disorder symptoms can occur across the lifespan – typically after exposure to chronic, repeated traumatic events and/or victimization that have continued for a period of months or years at a time.
- Symptoms of complex post-traumatic stress disorder are generally more severe and persistent in comparison to those of post-traumatic stress disorder.
- Exposure to repeated traumas, especially in early development, is associated with a greater risk of developing complex post-traumatic stress disorder rather than post-traumatic stress disorder.

Developmental presentations

- Complex post-traumatic stress disorder can occur at all ages, but responses to a traumatic event – that is, the core elements of the characteristic syndrome – can manifest differently depending on age and developmental stage. Because complex post-traumatic stress disorder and post-traumatic stress disorder share these same core elements, information provided in the *developmental presentations* section for post-traumatic stress disorder also applies to children and adolescents affected by complex post-traumatic stress disorder.
- Children and adolescents are more vulnerable than adults to developing complex post-traumatic stress disorder when exposed to severe, prolonged trauma such as chronic child abuse, participation in drug trafficking or being used as child soldiers. Many children and adolescents exposed to trauma have been exposed to multiple traumas, which increases the risk of developing complex post-traumatic stress disorder.

- Children and adolescents with complex post-traumatic stress disorder are more likely than their peers to demonstrate cognitive difficulties (e.g. problems with attention, planning, organizing) that may in turn interfere with academic and occupational functioning.
- In children, pervasive problems of affect regulation and persistent difficulties in sustaining relationships may manifest as regression, reckless behaviour or aggressive behaviours towards themselves or others, and in difficulties relating to peers. Furthermore, problems of affect regulation may manifest as dissociation, suppression of emotional experience and expression, and avoidance of situations or experiences that may elicit emotions, including positive emotions.
- In adolescence, substance use, risk-taking behaviours (e.g. unsafe sex, unsafe driving, non-suicidal self-harm) and aggressive behaviours may be particularly evident as expressions of problems of affect dysregulation and interpersonal difficulties.
- When parents or caregivers are the source of the trauma (e.g. sexual abuse), children and adolescents often develop a disorganized attachment style that can manifest as unpredictable behaviours towards these individuals (e.g. alternating between neediness, rejection and aggression). In children under 5 years of age, attachment disturbances related to maltreatment may also include reactive attachment disorder or disinhibited social engagement disorder, which can co-occur with complex post-traumatic stress disorder.
- Children and adolescents with complex post-traumatic stress disorder often report symptoms consistent with depressive disorders, eating and feeding disorders, sleep-wake disorders, attention deficit hyperactivity disorder, oppositional defiant disorder, conduct-dissocial disorder and separation anxiety disorder. The relationship of traumatic experiences to the onset of symptoms can be useful in establishing a differential diagnosis. At the same time, other mental disorders can also develop following extremely stressful or traumatic experiences. Additional co-occurring diagnoses should only be made if the symptoms are not fully accounted for by complex post-traumatic stress disorder, and all diagnostic requirements for each disorder are met.
- In older adults, complex post-traumatic stress disorder may be dominated by anxious avoidance of thoughts, feelings, memories and people, as well as physiological symptoms of anxiety (e.g. enhanced startle reaction, autonomic hyper-reactivity). Affected individuals may experience intense regret related to the impact of traumatic experiences on their lives.

Culture-related features

- Cultural variation exists in the expression of symptoms of complex post-traumatic stress disorder. For example, somatic or dissociative symptoms may be more prominent in certain groups, attributable to cultural interpretations of the psychological, physiological and spiritual etiology of these symptoms and of high levels of arousal.
- Given the severe, prolonged or recurrent nature of the traumatic events that precipitate complex post-traumatic stress disorder, collective suffering and the destruction of social bonds, networks and communities may present as a focal concern or as important related features of the disorder.
- For migrant communities – especially refugees or asylum seekers – complex post-traumatic stress disorder may be exacerbated by acculturative stressors and the social environment in the host country.

Sex- and/or gender-related features

- Females are at greater risk of developing complex post-traumatic stress disorder.
- Females with complex post-traumatic stress disorder are more likely to exhibit a greater level of psychological distress and functional impairment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with personality disorder

Many individuals with personality disorder have a history of traumatic events, particularly in childhood, and affective dysregulation can be a feature of both complex PTSD and personality disorder, particularly personality disorder with borderline pattern. However, there are several ways in which the specific symptom profiles of the two disorders differ. Avoidance of trauma-related reminders and a heightened sense of current threat are not diagnostic features of personality disorders. Intimate and interpersonal relationships in complex PTSD are less likely to be characterized by fear of abandonment and relationship instability, but rather by avoidance and a general sense of disconnection. Individuals with complex PTSD tend to manifest a stable but persistently negative self-view, in contrast to personality disorder in which an unstable sense of self is more common. Whereas personality disorder is more likely to be characterized by frequent impulsive behaviors, including impulsive suicidality, suicidality among individuals with complex PTSD tends to be less frequent, less impulsive, and of higher lethality. If the diagnostic requirements for both disorders are met, the utility of assigning an additional diagnosis of personality disorder depends on the specific clinical situation.

Boundary with other mental, behavioural and neurodevelopmental disorders

Because the diagnostic requirements for complex post-traumatic stress disorder include all essential features of post-traumatic stress disorder, guidance provided in the sections on boundary with normality (threshold) and boundaries with other disorders and conditions (differential diagnosis) for post-traumatic stress disorder also applies to complex post-traumatic stress disorder.

6B42 Prolonged grief disorder

Essential (required) features

- A history of bereavement following the death of a partner, parent, child or other person close to the bereaved is required for diagnosis.

- A persistent and pervasive grief response is characterized by longing for the deceased or persistent preoccupation with the deceased, accompanied by intense emotional pain. This may be manifested in experiences such as sadness, guilt, anger, denial, blame, difficulty accepting the death, the individual feeling that they have lost a part of themselves, an inability to experience positive mood, emotional numbness and difficulty in engaging with social or other activities.
- The pervasive grief response has persisted for an atypically long period of time following the loss, markedly exceeding expected social, cultural or religious norms for the individual's culture and context. Grief responses lasting for less than 6 months, and for longer periods in some cultural contexts, should not be regarded as meeting this requirement.
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Persistent preoccupation may focus on the circumstances of the death, or manifest as behaviours such as the preservation of all the deceased person's belongings exactly as they were before their death. The individual may alternate between excessive preoccupation and avoidance of reminders of the deceased.
- Other features of prolonged grief disorder may include problems coping without the loved one, difficulties in recalling positive memories of the deceased, difficulty trusting others, social withdrawal and the feeling that life is meaningless.
- Increased tobacco, alcohol and other substance use, as well as increased suicidal ideation and behaviour, may be present.

Boundary with normality (threshold)

- An individual experiencing a grief reaction that is within a normative period given their cultural and religious context is considered to be experiencing normal bereavement, and should not be assigned a diagnosis of prolonged grief disorder. It is often important to consider whether other people who share the bereaved person's cultural or religious perspective (e.g. family, friends, community) regard the response to the loss or duration of the reaction as abnormal.
- Children and adolescents may respond to the loss of a primary attachment figure (e.g. a parent or caregiver) with an intense and sustained grief response (e.g. greater in intensity, symptomatology, duration) because of the role these individuals play in the child's life. Preschool-aged children commonly have difficulty accepting the loss. Aspects of the grief response may be retriggered at various points during the individual's development – for example, as new needs arise that would normally be supplied by the parent or caregiver. Generally, these reactions should be regarded as normal, and the diagnosis of prolonged grief disorder should be assigned with caution to children and adolescents in this situation.

Developmental presentations

- Prolonged grief disorder can occur at all ages, but the grief response can differ depending on the age and developmental stage, and thus on age-specific concepts of death.
- Children often do not explicitly describe the experience of longing for the deceased or persistent preoccupation with the death of a loved one. These symptoms may be more likely to manifest behaviourally, such as in play or in other behaviours involving themes of separation or death. Other behavioural expressions of longing can include waiting for the deceased person to return or returning to places where they last saw the deceased. Some children may develop a fearful preoccupation that others may die, or separation anxiety centring on worries about their caregivers' welfare and safety.
- In younger children, intense sadness or emotional pain may emerge intermittently with seemingly appropriate moods. Anger related to the loss may be exhibited in children and adolescents as irritability, protest behaviour, tantrums, oppositional behaviour or conduct problems.
- Various contextual factors can influence symptoms related to the death of a loved one in children. For example, delayed onset or worsening of symptoms may occur in response to a change in a child or adolescent's social environment, the degree of coping of parents or caregivers with the loss, and family communication.
- In older adults, prolonged grief disorder may manifest as enduring depression, with the feeling that they have lost a part of themselves, and accentuated feelings of emptiness. Feelings of being stunned and dazed over the loss are common. A preoccupation with somatic complaints is often found to be the primary sign of distress at this developmental stage.

Culture-related features

- Cultural practices vary with regard to appropriate emotional expressions of bereavement, rituals and practices for managing the grieving process, modes of commemorating the deceased, concepts of an afterlife, stigma associated with certain types of death (e.g. suicide) or situations that may be especially traumatic (e.g. death of a child). This variation may contribute to the likelihood of experiencing prolonged grief reactions, and to the range of symptoms and clinical presentations.
- Cultural groups vary regarding the normative duration of grief reactions. Among some groups, prescribed grief reactions may last for 1 year, or may even be postponed until the first anniversary. Among others, rituals or ceremonies are expected to prompt negative emotions related to loss, and formal grieving periods are relatively short. It is often important to consider whether other people who share the bereaved person's cultural or religious perspective (e.g. family, friends, community) regard the response to the loss or duration of the reaction as abnormal.
- In some cultural or religious traditions, death is seen not as the cessation of life but as an important transition to another form of existence. Such cultural beliefs may focus on karma, rebirth, heaven/hell, purgatory or other transitions into the afterlife. Culturally

specific rituals and yearly celebrations may aim to assure the auspicious spiritual status of the deceased. Prolonged grief may be associated with concern about the status of the deceased in the afterlife.

- Encounters with the deceased may vary greatly across cultures. For example, in some societies, any waking encounter with the deceased is considered abnormal. By contrast, it is common in many southern European and Latin American societies to receive visitations from deceased relatives soon after their death, which may be comforting to the bereaved. Other groups (e.g. some American Indians) may encounter the deceased in dreams, with a variety of interpretations. Among Cambodians, for example, having dreams of the deceased may be highly upsetting, indicating that rebirth has not occurred.

Sex- and/or gender-related features

- Prolonged grief disorder is more prevalent among females.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with post-traumatic stress disorder

As with post-traumatic stress disorder, prolonged grief disorder may occur in individuals who experience bereavement as a result of the death of a loved one occurring in traumatic circumstances. In prolonged grief disorder the person may be preoccupied with memories of the circumstances surrounding the death, but unlike in post-traumatic stress disorder, they do not re-experience them as occurring again in the here and now.

Boundary with depressive episode

Some common symptoms of prolonged grief disorder are similar to those observed in a depressive episode (e.g. sadness, loss of interest in activities, social withdrawal, feelings of guilt, suicidal ideation). However, prolonged grief disorder is differentiated from a depressive episode because symptoms are specifically focused on the loss of the loved one, whereas depressive thoughts and emotional reactions typically encompass multiple areas of life. Further, other common symptoms of prolonged grief disorder (e.g. difficulty accepting the loss, feeling angry about the loss, feeling as though a part of the individual has died) are not characteristic of a depressive episode. The timing of the onset of the symptoms in relation to the loss and whether there is a prior history of depressive or bipolar disorder are important to consider in making this distinction. However, prolonged grief disorder and mood disorders can co-occur, and both should be diagnosed if the full diagnostic requirements for each are met.

6B43 Adjustment disorder

Essential (required) features

- A maladaptive reaction to an identifiable psychosocial stressor or multiple stressors (e.g. single stressful event, ongoing psychosocial difficulty or a combination of stressful life situations) that usually emerges within a month of the stressor is required for diagnosis. Examples include divorce or loss of a relationship, loss of a job, diagnosis of an illness, recent onset of a disability, and conflicts at home or work.
- The reaction to the stressor is characterized by preoccupation with the stressor or its consequences, including excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications.
- The symptoms are not better accounted for by another mental disorder (e.g. a mood disorder, another disorder specifically associated with stress).
- Once the stressor and its consequences have ended, the symptoms resolve within 6 months.
- Failure to adapt to the stressor results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Symptoms of preoccupation may worsen with reminders of the stressor, resulting in avoidance of stimuli, thoughts, feelings or discussions associated with the stressor to prevent preoccupation or distress.
- Additional psychological symptoms of adjustment disorder may include depressive or anxiety symptoms, as well as impulsive "externalizing" symptoms – particularly increased tobacco, alcohol or other substance use.
- Symptoms of adjustment disorder usually abate when the stressor is removed, when sufficient support is provided, or when the affected person develops additional coping mechanisms or strategies.

Boundary with normality (threshold)

- Adjustment disorder represents a maladaptive reaction and failure to adapt to a stressor that is associated with significant preoccupation, and results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Emotional reactions to negative life events that do not meet these requirements should not be diagnosed as adjustment disorder.

- Symptoms that occur as transient responses and resolve within a few days do not typically warrant a diagnosis of adjustment disorder.
- In cases in which responses to traumatic events are considered normal given the severity of the stressor, a diagnosis of acute stress reaction from Chapter 24 on factors influencing health status or contact with health services (i.e. a non-disorder category) is generally most appropriate.

Course features

- Onset of adjustment disorder usually occurs within 1 month after exposure to a stressful life event (i.e. illness, marital distress). However, onset can occur after a longer delay (e.g. 3 months after exposure).
- Acute and intense stressful life events (e.g. sudden job loss) typically result in a correspondingly precipitous onset of symptoms that tend to have a shorter duration, whereas more persistent stressful life events (e.g. ongoing marital distress) typically result in delayed onset of symptoms and a longer duration.
- The intensity and duration of adjustment disorder varies widely.

Developmental presentations

- In children, the characteristic symptoms of preoccupation with a stressor or its consequences or constant rumination about the stressor are often not expressed directly but rather are manifested in somatic symptoms (e.g. stomach pains or headaches), disruptive or oppositional behaviour, hyperactivity, tantrums, concentration problems, irritability and increased clinginess. Other reactions to stressors – including regression, bedwetting and sleep disturbances – may be a manifestation of adjustment disorder if they are persistent (e.g. have been present for approximately 1 month).
- In adolescents, behavioural manifestations of adjustment disorder can include substance use and various forms of acting out or risk-taking.
- Because children and adolescents may not explicitly verbalize a connection between stressful events and their own symptoms and behaviours, in making the diagnosis it is important to consider the temporal relationship between the stressor and the onset of symptoms, and the extent to which they constitute a change from prior functioning.
- Among older adults, preoccupation with somatic complaints is a common sign of distress related to stressors. Older adults who suffer from adjustment disorder tend to express greater anxiety about their health, report significant demoralization, and often display persistent somatization of psychological symptoms.

Culture-related features

- Adjustment disorder may be exacerbated in the context of limited family or community support, particularly in collectivistic or sociocentric cultures. In these societies, the focus of the preoccupation may extend to stressors affecting close relatives or friends.
- Symptoms of adjustment disorder may be influenced by local idioms associated with fear (e.g. *susto* or *espanto* (fright) in Latin America) or preoccupation with stressors that have strong cultural connotations (e.g. intense fear related to crossing unpopulated areas alone at night).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with post-traumatic stress disorder

In adjustment disorder, the stressor can be of any severity or any type, and is not necessarily of an extremely threatening or horrific nature. A response to a less serious event or situation that otherwise meets the symptom requirements for post-traumatic stress disorder should be diagnosed as adjustment disorder. Moreover, many people who have experienced an extremely threatening or horrific event develop adjustment disorder and not post-traumatic stress disorder in its aftermath. The distinction should be made based on whether the full diagnostic requirements for either disorder are met, not solely on the type of stressor.

Boundary with other mental disorders

It is common for mental disorders to be triggered or exacerbated by stressful life experiences. Moreover, many mental disorders can involve symptoms including maladaptive reactions to stressors, preoccupation with stressors and excessive worry or rumination, and failure to adapt. In the presence of another mental disorder that can account for these symptoms (e.g. a primary psychotic disorder, a mood disorder, another disorder specifically associated with stress, a personality disorder, an obsessive-compulsive or related disorder, generalized anxiety disorder, separation anxiety disorder, autism spectrum disorder), a separate diagnosis of adjustment disorder should generally not be assigned, even if stressful life events or changing circumstances have led to an exacerbation of the symptoms. However, a diagnosis of adjustment disorder may be assigned in the presence of other mental disorders with substantially non-overlapping symptomatology (e.g. specific phobia, panic disorder, bodily distress disorder) that do not fully account for the adjustment disorder symptoms, as long as the course of the two disorders is distinguishable and the full diagnostic requirements are met for each. If symptoms persist for longer than 6 months after a stressor has ended, it is generally appropriate to change the diagnosis to another relevant mental disorder.

6B44 Reactive attachment disorder

Essential (required) features

- A history of grossly insufficient care is required for diagnosis, which may include:
  - persistent disregard for the child's basic emotional needs for comfort, stimulation and affection;
  - persistent disregard for the child's basic physical needs;
  - repeated changes of primary caregivers (e.g. frequent changes in foster-care providers);
  - rearing in unusual settings (e.g. institutions) that prevent formation of stable selective attachments;
  - maltreatment.
- Markedly abnormal attachment behaviours towards adult caregivers in a child are characterized by a persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour including both of the following:
  - minimal seeking of comfort when distressed;
  - rare or minimal response to comfort when it is offered.
- The grossly insufficient care is presumed to be responsible for the persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour.
- The symptoms are evident before the age of 5 years.
- The child has reached a developmental level by which the capacity to form selective attachments with caregivers normally develops, which typically occurs at a chronological age of 1 year or a developmental age of at least 9 months.
- The abnormal attachment behaviours are not better accounted for by autism spectrum disorder.
- The abnormal attachment behaviours are not confined to a specific dyadic relationship.

Additional clinical features

- Persistent disregard for the child's basic needs may meet the definition for neglect: egregious acts or omissions by a caregiver that deprive a child of needed age-appropriate care and that result, or have reasonable potential to result, in physical or psychological harm. Reactive attachment disorder is associated with persistent neglect rather than isolated incidents.
- Reactive attachment disorder may also be associated with persistent maltreatment, characterized by one or more of the following:
  - non-accidental acts of physical force that result – or have reasonable potential to result – in physical harm, or that evoke significant fear;
  - sexual acts involving a child that are intended to provide sexual gratification to an adult;
  - non-accidental verbal or symbolic acts that result in significant psychological harm.

- Children with reactive attachment disorder related to repetitive maltreatment (e.g. chronic physical or sexual abuse) are at risk of developing co-occurring post-traumatic stress disorder or complex post-traumatic stress disorder.
- Children with reactive attachment disorder often exhibit more generalized persistent social and emotional disturbances, including a relative lack of social and emotional responsiveness to others and limited positive affect. There may be episodes of unexplained irritability, sadness or fearfulness that are evident during non-threatening interactions with adult caregivers.
- Children with a history of grossly insufficient care but who have nonetheless formed selective attachments do not appear to develop reactive attachment disorder, but they may still be at risk of developing disinhibited social engagement disorder.

Boundary with normality (threshold)

- Many children without a diagnosis of reactive attachment disorder show transient reductions of attachment behaviours towards a parent or caregiver as a normal part of development. In contrast, children with reactive attachment disorder exhibit markedly atypical social responses towards caregivers that persist over time, extend across all social situations, and are not confined to a dyadic relationship with a particular caregiver.

Course features

- With the provision of adequate care, children with reactive attachment disorder often experience a near or complete remission of symptoms. If appropriate caregiving is not provided, the disorder can persist for several years.
- Children with reactive attachment disorder are at higher risk of developing depressive disorders and other internalizing disorders during adolescence and adulthood. They may also experience problems in developing and maintaining healthy interpersonal relationships.
- Information about the course features of reactive attachment disorder beyond the childhood years is limited.
- Some adults with a history of reactive attachment disorder may experience difficulty in developing interpersonal relationships.

Developmental presentations

- Caregiver neglect during the first 9 months of life is often an associated precursor to the onset of the disorder.
- The features of this disorder become noticeable in a similar fashion up to 5 years of age.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with autism spectrum disorder

In contrast to individuals with autism spectrum disorder, children with reactive attachment disorder have the capacity for initiating and sustaining social communication and reciprocal social interactions. Although some children with reactive attachment disorder may show delays in language development due to a history of social neglect, they do not exhibit social communication deficits or the persistently restrictive, repetitive and stereotyped patterns of behaviour, interests and activities characteristics of autism spectrum disorder. Some individuals reared under conditions of severe deprivation in institutional settings exhibit autistic-like features, including difficulties in social reciprocity and restricted, repetitive and inflexible patterns of behaviour, interests or activities. Also referred to as "quasi-autism", affected individuals are differentiated from those with autism spectrum disorder based on significant improvement of autism-like features when the child is moved to a more nurturing environment.

Boundary with disorders of intellectual development

Children with disorders of intellectual development are able to form selective attachments to caregivers. Attachments usually develop consistent with the child's general developmental level, and are typically evident by the time the child has reached a developmental age of at least 9 months. Reactive attachment disorder should only be diagnosed if it is clear that the characteristic problems in the formation of selective attachments are not a result of limitations in intellectual functioning.

Boundary with social anxiety disorder

Social anxiety disorder in children may include emotionally withdrawn behaviours in social situations, or in anticipation of social encounters, due to marked and excessive fear or anxiety. Unlike in reactive attachment disorder, children with social anxiety disorder exhibit appropriate attachment behaviours with parents or caregivers, and seek comfort from them when distressed, but are typically fearful of unfamiliar individuals. Children with reactive attachment disorder exhibit emotionally withdrawn behaviours across all social contexts.

Boundary with depressive disorders

As with reactive attachment disorder, children with depressive disorders may exhibit emotionally withdrawn behaviour, as well as associated features of lack of social and emotional responsiveness to others, limited positive affect and/or episodes of unexplained irritability, sadness or fearfulness. However, unlike those with reactive attachment disorder, children with depressive disorders exhibit appropriate attachment behaviours with parents or caregivers, and seek comfort from them when distressed.

6B45 Disinhibited social engagement disorder

Essential (required) features

- A history of grossly insufficient care of a child is required for diagnosis, which may include:
  - persistent disregard for the child's basic emotional needs for comfort, stimulation and affection;
  - persistent disregard for the child's basic physical needs;
  - repeated changes of primary caregivers (e.g. frequent changes in foster-care providers);
  - rearing in unusual settings (e.g. institutions) that prevent formation of stable selective attachments;
  - maltreatment.
- A persistent and pervasive pattern of markedly abnormal social behaviours in a child, in which the child displays reduced or absent reticence in approaching and interacting with unfamiliar adults, including one or more of the following:
  - overly familiar behaviour with unfamiliar adults, including verbal or physical violation of socially appropriate physical and verbal boundaries (e.g. seeking comfort from unfamiliar adults, asking age-inappropriate questions to unfamiliar adults);
  - diminished or absent checking back with an adult caregiver after venturing away, even in unfamiliar settings;
  - a willingness to go off with an unfamiliar adult with minimal or no hesitation.
- The symptoms are evident before the age of 5 years.
- The child has reached a developmental level by which the capacity to form selective attachments with caregivers normally develops, which typically occurs at a chronological age of 1 year or a developmental age of at least 9 months.
- The disinhibited social engagement behaviour is not better accounted for by another mental disorder (e.g. attention deficit hyperactivity disorder).

Additional clinical features

- Persistent disregard for the child's basic needs may meet the definition for neglect: egregious acts or omissions by a caregiver that deprive a child of needed age-appropriate care and that result, or have reasonable potential to result, in physical or psychological harm. Disinhibited social engagement disorder is associated with persistent neglect rather than isolated incidents.
- Disinhibited social engagement disorder may also be associated with persistent maltreatment, characterized by one or more of the following:
  - non-accidental acts of physical force that result, or have reasonable potential to result, in physical harm or that evoke significant fear;
  - sexual acts involving a child that are intended to provide sexual gratification to an adult;
  - non-accidental verbal or symbolic acts that results in significant psychological harm.

- Children with a history of grossly insufficient care are at increased risk of developing disinhibited social engagement disorder – particularly when it occurs very early (e.g. prior to the age of 2 years). However, disinhibited social engagement disorder is rare, and most children with such a history do not develop the disorder.
- In contrast to reactive attachment disorder, symptoms of disinhibited social engagement disorder tend to be more persistent following the provision of appropriate care, even with the development of selective attachments.
- Children with disinhibited social engagement disorder related to repetitive maltreatment (e.g. chronic physical or sexual abuse) are at risk of developing co-occurring post-traumatic stress disorder or complex post-traumatic stress disorder.
- General impulsivity is commonly associated with disinhibited social engagement disorder, particularly among older children, and there is a high rate of co-occurrence with attention deficit hyperactivity disorder.

Boundary with normality (threshold)

- Children vary greatly in their temperamental features, and disinhibited social engagement disorder should be distinguished from the ebullience associated with an outgoing temperamental style. Distinguishing features of the disinhibited social engagement disorder are the dysfunctional nature of the behaviour and its association with a history of grossly insufficient care.

Course features

- Disinhibited social engagement disorder is moderately stable, and symptoms may persist throughout childhood and adolescence. Overly friendly behaviour appears to be relatively resistant to change.
- Individuals with disinhibited social engagement disorder who lived in institutions for an extended period of time appear to be at greatest risk of persistent symptoms, even after adoption. Early removal from an adverse environment decreases the likelihood that indiscriminate social behaviours will persist. Only some individuals with disinhibited social engagement disorder appear to respond to interventions targeting enhancement of caregiving.
- In adolescence, individuals with a history of disinhibited social engagement disorder demonstrate superficial peer relationships (e.g. identification of acquaintances as close friends) and other deficits in social functioning (e.g. increased conflict with peers).
- During childhood, disinhibited social engagement disorder often manifests in violation of socially appropriate physical (e.g. seeking comfort from unfamiliar adults) and verbal boundaries (e.g. asking inappropriate questions to unfamiliar adults).

Developmental presentations

- Children and adolescents are at greater risk of disinhibited social engagement disorder if they have experienced seriously neglectful caregiving and adverse environments, such as institutions – particularly if this occurred prior to the age of 2 years. However, disinhibited social engagement disorder is relatively rare, and not all children or adolescents with a history of experiencing such environments go on to develop disinhibited social engagement disorder.
- Individuals with disinhibited social engagement disorder may or may not have developed selective attachment to caregivers.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with attention deficit hyperactivity disorder

As with disinhibited social engagement disorder, children with attention deficit hyperactivity disorder may display socially disinhibited behaviour. Disinhibited social engagement disorder is distinguished by specific behaviours with unfamiliar adults and its association with a history of grossly insufficient care. However, children with disinhibited social engagement disorder often exhibit inattention, general impulsivity and hyperactivity. Rates of attention deficit hyperactivity disorder are elevated among children with disinhibited social engagement disorder, and both disorders may be diagnosed if all diagnostic requirements for each are met.

Boundary with disorders of intellectual development

Children with a disorder of intellectual development may exhibit atypical social behaviours. However, these are usually consistent with the child's general developmental level. Children with disorders of intellectual development are able to form selective attachments to caregivers by the time they have reached a developmental age of at least 9 months. Disinhibited social engagement disorder should only be diagnosed if it is clear that the characteristic problems in social behaviour are not a result of limitations in intellectual functioning.

Boundary with diseases of the nervous system, developmental anomalies and other conditions originating in the perinatal period

Indiscriminate social engagement may be a result of brain damage or a feature of neurological syndromes such as Williams syndrome or fetal alcohol syndrome. These conditions are differentiated from disinhibited social engagement disorder by confirmatory clinical features and laboratory investigations, and typically by the absence of a history of grossly insufficient care.

6B4Y Other specified disorder specifically associated with stress

Essential (required) features

- The presentation is characterized by stress-related symptoms that share primary clinical features with other disorders specifically associated with stress (e.g. occurring in specific association with an identifiable stressor).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the grouping of disorders specifically associated with stress or for acute stress reaction.
- The symptoms are not better accounted for by another mental disorder (e.g. a mood disorder or an anxiety or fear-related disorder).
- The symptoms are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6B4Z Disorder specifically associated with stress, unspecified

Secondary-parented category in disorders specifically associated with stress

QE84 Acute stress reaction

Note: acute stress reaction is not considered to be a mental disorder but rather appears in Chapter 24 on factors influencing health status or contact with health services. It is listed here to assist in differential diagnosis.

Essential (required) features

- Exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature is required for diagnosis. Such events include, but are not limited to, directly experiencing natural or human-made disasters, combat, serious accidents, torture,

sexual violence, terrorism; assault, acute life-threatening illness (e.g. a heart attack); witnessing the threatened or actual injury or death of others in a sudden, unexpected, or violent manner; and learning about the sudden, unexpected or violent death of a loved one.

- There is a response to the stressor that is considered to be normal, given the severity of the stressor. The response to the stressor may include transient emotional, somatic, cognitive or behavioural symptoms, such as being in a daze, confusion, sadness, anxiety, anger, despair, overactivity, inactivity, social withdrawal, amnesia, depersonalization, derealization or stupor. Autonomic signs of anxiety (e.g. tachycardia, sweating, flushing) are common, and may be the presenting feature.
- Symptoms typically appear within hours to days following the stressful event, and usually begin to subside within a few days after the event or following removal from the threatening situation, when this is possible. In cases where the stressor is ongoing or removal is not possible, symptoms may persist, but are usually greatly reduced within approximately 1 month as the person adapts to the changed situation.

Additional clinical features

- Acute stress reaction in help-seeking individuals is usually, but not necessarily, accompanied by substantial subjective distress and/or interference with personal functioning.

Developmental presentations

- In children, responses to stressful events can include somatic symptoms (e.g. stomach pains or headaches), disruptive or oppositional behaviour, regression, hyperactivity, tantrums, concentration problems, irritability, withdrawal, excessive daydreaming, increased clinginess, bedwetting and sleep disturbances. In adolescents, responses can include substance use and various forms of acting out or risk-taking.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with adjustment disorder and post-traumatic stress disorder

If symptoms have not begun to diminish within about 1 week of the stressor ceasing (or within about 1 month in the case of continuing stressors), a diagnosis such as adjustment disorder or post-traumatic stress disorder should be considered, depending on the nature of the symptoms.

Boundary with acute and transient psychotic disorder

Acute and transient psychotic disorder, like acute stress reaction, has an acute onset and may occur in response to a traumatic experience. Acute stress reaction does not typically include psychotic symptoms such as hallucinations or delusions that are characteristic of acute and transient psychotic disorder.

Boundary with other mental disorders

The symptoms do not meet the diagnostic requirements for another mental disorder, such as acute and transient psychotic disorder, a depressive disorder, an anxiety or fear-related disorder, or a dissociative disorder.

Dissociative disorders

Dissociative disorders are characterized by involuntary disruption or discontinuity in the normal integration of one or more of the following: identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements or behaviour. Disruption or discontinuity may be complete, but is more commonly partial, and can vary from day to day or even from hour to hour. Experiences that are part of an accepted cultural, religious or spiritual practice should not be viewed as symptoms of dissociative disorders.

Dissociative disorders include the following:

6B60	Dissociative neurological symptom disorder
6B61	Dissociative amnesia
6B62	Trance disorder
6B63	Possession trance disorder
6B64	Dissociative identity disorder
6B65	Partial dissociative identity disorder
6B66	Depersonalization-derealization disorder
6B6Y	Other specified dissociative disorder
6B6Z	Dissociative disorder, unspecified.

6B60 Dissociative neurological symptom disorder

Essential (required) features

- Involuntary disruption or discontinuity in the normal integration of motor, sensory or cognitive functions, lasting at least several hours, is required for diagnosis.
- Clinical findings are not consistent with a recognized disease of the nervous system (e.g. a stroke) or another medical condition (e.g. a head injury).
- The symptoms do not occur exclusively during episodes of trance disorder, possession trance disorder, dissociative identity disorder or partial dissociative identity disorder.
- The symptoms are not due to the effects of a substance or medication on the central nervous system (including withdrawal effects), do not occur exclusively during hypnagogic or hypnopompic states, and are not due to a sleep-wake disorder (e.g. sleep-related rhythmic movement disorder, recurrent isolated sleep paralysis).
- The symptoms are not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder, post-traumatic stress disorder).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Symptom specifiers

Specific presenting symptoms in dissociative neurological symptom disorder may be identified using the following symptom specifiers. Multiple specifiers may be assigned as necessary to describe the clinical presentation.

6B60.0 with visual disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by visual symptoms such as blindness, tunnel vision, diplopia, visual distortions or hallucinations that are not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.

6B60.1 with auditory disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by auditory symptoms such as loss of hearing or auditory hallucinations that are not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.

6B60.2 with vertigo or dizziness

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by a sensation of spinning while stationary (vertigo) or dizziness that is not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and does not occur exclusively during another dissociative disorder.

6B60.3 with other sensory disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by sensory symptoms not identified in other specific categories in this grouping such as numbness, tightness, tingling, burning, pain or other symptoms related to touch, smell, taste, balance, proprioception, kinaesthesia or thermoception. The symptoms are not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.

6B60.4 with non-epileptic seizures

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by a symptomatic presentation of seizures or convulsions that are not consistent with a recognized disease of the nervous system, another mental disorder or another health condition, and do not occur exclusively during another dissociative disorder.

6B60.5 with speech disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by symptoms such as difficulty with speaking (dysphonia), loss of the ability to speak (aphonia) or difficult or unclear articulation of speech (dysarthria) that are not consistent with a recognized disease of the nervous system, a neurodevelopmental or neurocognitive disorder, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.

6B60.6 with paresis or weakness

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by a difficulty or inability to intentionally move parts of the body or to coordinate movements that is not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and does not occur exclusively during another dissociative disorder.

6B60.7 with gait disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by symptoms involving the individual's ability or manner of walking, including ataxia and the inability to stand unaided, that are not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.

6B60.8 with movement disturbance

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by symptoms such as chorea, myoclonus, tremor, dystonia, facial spasm, parkinsonism or dyskinesia that are not consistent with a recognized disease of the nervous system, another mental disorder or another medical condition, and do not occur exclusively during another dissociative disorder.
- If it is clinically relevant, one or more forms of movement disturbance may be specified.

6B60.80 with chorea

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by involuntary, irregular, non-repetitive, brief, jerky and flowing movements that move randomly from one part of the body to another.

6B60.81 with myoclonus

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by sudden, involuntary twitching or jerking of a muscle or group of muscles.

6B60.82 with tremor

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by involuntary oscillation of a body part, which can occur during attempted relaxation, during a voluntarily held posture, or during a voluntary movement.

6B60.83 with dystonia

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by involuntary muscle contractions that cause slow repetitive movements or abnormal postures.

6B60.84 with facial spasm

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by involuntary twitching or contraction of the facial muscles, similar in appearance to tics. Twitching may be intermittent or nearly continuous.

6B60.85 with parkinsonism

- This specifier can be applied if the movement disturbance in dissociative neurological symptom disorder is characterized by rest tremor, muscular rigidity, akinesia (absence of movement) or bradykinesia (slowness of movement), and postural disturbances that include a shuffling gait, flexed posture and loss of postural reflexes.

6B60.8Y with other specified movement disturbance

6B60.8Z with unspecified movement disturbance

6B60.9 with cognitive symptoms

- This specifier can be applied if the dissociative neurological symptom disorder is characterized by impaired cognitive performance in memory, language or other cognitive domains that is internally inconsistent and not consistent with a recognized disease of the nervous system, a neurodevelopmental or neurocognitive disorder, another mental disorder or another medical condition, and does not occur exclusively during another dissociative disorder.

6B60.Y with other specified symptoms

6B60.Z with unspecified symptoms

Boundary with normality (threshold)

- Transient alterations in sensory or cognitive functions that can accompany intense engagement in work or sports, or intense emotional states and transient difficulties in coordinating movements (e.g. during situations of intense anxiety) are relatively common,

and do not result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Such transient experiences should not be considered as symptomatic of dissociative neurological symptom disorder.

- Experiences resembling dissociative neurological symptom disorder can occur as a part of culturally sanctioned rituals, and in some cases can persist for several months (e.g. following a death). If such presentations are not associated with impairment in functioning, a diagnosis of dissociative neurological symptom disorder should not be assigned. Depending on the nature of the circumstances preceding the onset of symptoms, and their duration, acute stress reaction may be considered.

Course features

- Onset of dissociative neurological symptom disorder typically occurs between puberty and early adulthood; although onset in early childhood (as young as the age of 3 years) has been observed, it is extremely rare. Onset after the age of 35 years is uncommon.
- The onset of dissociative neurological symptom disorder is usually acute, and the disorder may follow either a transient or a persistent course. Symptoms are typically of brief duration (e.g. remission within 2 weeks) but commonly recur.
- Onset is often associated with a traumatic or adverse life event. Prior physical injury and a history of childhood abuse or neglect are risk factors for dissociative neurological symptom disorder. In addition, a prior disease of the nervous system is a risk factor for the disorder; for example, individuals with a history of epilepsy are more likely to exhibit non-epileptic seizures. Patients may also present with symptoms that closely resemble the symptoms of physical illnesses experienced by their friends or family members.
- Non-epileptic seizures are more likely to have their onset earlier in the lifespan than motor symptoms.
- Positive prognostic factors include younger age, acute onset, onset associated with a clearly identifiable stressor, early diagnosis, monosymptomatic presentation, short duration of symptoms, and short interval between symptom onset and initiation of treatment. Patients with good premorbid adjustment and above-average intelligence, and those who accept the psychological nature of the disorder also have a better prognosis. Negative prognostic factors include non-transient symptoms, polysymptomatic presentation, the presence of comorbid medical conditions and co-occurring mental disorders (e.g. mood disorders or anxiety and fear-related disorders). Patients with maladaptive personality traits, history of sexual abuse or poor physical functioning prior to diagnosis also have a poorer prognosis.
- Individuals with symptoms of paralysis, aphonia, blindness or deafness tend to have a better prognosis than those with symptoms of tremor or non-epileptic seizures.

Developmental presentations

- Onset of dissociative neurological symptom disorder in childhood is often associated with minor illness or physical injury.

- Gait disturbances and non-epileptic seizures are the most prominent and the most frequent symptoms of dissociative neurological symptom disorder in children and adolescents. The range and number of symptoms observed often expands with age and duration of the disorder.
- The most common psychosocial stressors associated with dissociative neurological symptom disorder in children include bullying or victimization, school-related stressors, family conflict or parental separation, and the death of a relative or friend.
- Individuals with dissociative neurological symptom disorder often grow up in families that are excessively preoccupied with illness.
- Adolescents with dissociative neurological symptom disorder frequently have co-occurring mood disorders, anxiety and fear-related disorders, and other medical symptoms. Mood and/or anxiety and fear-related disorders often persist even after remission of the symptoms of dissociative neurological symptom disorder. Among adolescents, dissociative neurological symptom disorder is more likely to be transient.

Culture-related features

- Symptoms of dissociative neurological symptom disorder that are typical in one cultural context may be considered unusual in another, such as localized heat sensations, "peppery" feelings on the skin, and sensations of being touched or pushed. These symptoms may be connected to local expressions of distress that reference cultural explanations of etiology (e.g. spiritual origins) or pathophysiology (e.g. subtle energies). Alternatively, in some cultures, dissociative symptoms may be attributed to an undiagnosed physical illness, such as occurs in hypochondriasis (health anxiety disorder); response to reassurance may suggest hypochondriasis rather than a dissociative disorder.
- Dissociative seizures and convulsions tend to have higher prevalence in low- and middle-income countries and communities. Variations in prevalence may reflect greater traumatic exposure, sanctions against verbal expressions of disagreement by people with marginalized status, or cultures in which somatic expressions of distress are more common. Lower prevalence of dissociative symptoms may be related to negative cultural views of such "out-of-control" behaviour.

Sex- and/or gender-related features

- Dissociative neurological symptom disorder is 2–3 times more frequently diagnosed among females, who also have a younger age of onset.
- In men, dissociative neurological symptom disorder is associated with a history of industrial, military or other occupational accident. In women, symptoms are more often linked to stress caused by family or other interpersonal interactions.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with dissociative amnesia

Dissociative amnesia involves memory deficits that manifest as an inability to recall important autobiographical memories – typically of recent traumatic or stressful events. The memory deficits are inconsistent with ordinary forgetting, and are not due to the direct effects of a substance or a disease of the nervous system. If cognitive symptoms are narrowly focused on autobiographical memory, dissociative amnesia is the more appropriate diagnosis. Cognitive symptoms presented in dissociative neurological symptom disorder involve other cognitive phenomena.

Boundary with other dissociative disorders

Dissociative motor, sensory or cognitive symptoms are commonly a part of the clinical presentation of trance disorder, possession trance disorder, dissociative identity disorder and partial dissociative identity disorder. A separate diagnosis of dissociative neurological symptom disorder should not be assigned if the symptoms occur exclusively during symptomatic episodes of another dissociative disorder.

Boundary with factitious disorder and malingering

In dissociative neurological symptom disorder, despite the presented symptoms (e.g. seizures, paralysis) not being consistent with neurological findings or other pathophysiology, the symptoms are not feigned, falsified or intentionally induced as in factitious disorder or malingering.

Boundary with other mental disorders

Somatic symptoms that are not consistent with an identified medical condition also occur in bodily distress disorder, and a variety of somatic symptoms may also occur in schizophrenia and other primary psychotic disorders, mood disorders, anxiety and fear-related disorders, obsessive-compulsive and related disorders, and disorders specifically associated with stress. Dissociative neurological symptom disorder should not be diagnosed if the symptoms are accounted for by another mental disorder.

Boundary with diseases of the nervous system and other medical conditions classified elsewhere

The diagnosis of dissociative neurological symptom disorder requires a medical evaluation to rule out diseases of the nervous system and other medical conditions as the cause of the presenting motor, sensory or cognitive symptoms. In dissociative neurological symptom disorder, clinical and laboratory findings are inconsistent with recognized symptoms of diseases of the nervous system or other medical conditions as indicated by an alternative examination method (e.g. normal simultaneous electroencephalogram (EEG) during an apparent seizure or convulsion).

6B61 Dissociative amnesia

Essential (required) features

- Inability to recall important autobiographical memories – typically of recent traumatic or stressful events – that is inconsistent with ordinary forgetting is required for diagnosis.
- The memory loss does not occur exclusively during episodes of trance disorder, possession trance disorder, dissociative identity disorder or partial dissociative identity disorder, and is not better accounted for by another mental disorder (e.g. post-traumatic stress disorder, complex post-traumatic stress disorder, a neurocognitive disorder such as dementia).
- The symptoms are not due to the effects of a substance or medication on the central nervous system (e.g. alcohol) – including withdrawal effects – and are not due to a disease of the nervous system (e.g. temporal lobe epilepsy), another medical condition (e.g. a brain tumour) or head trauma.
- The memory loss results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Presence or absence of dissociative fugue

6B61.0 Dissociative amnesia with dissociative fugue

- Dissociative amnesia with dissociative fugue is characterized by all the features of dissociative amnesia, accompanied by dissociative fugue – i.e. a loss of a sense of personal identity and sudden travel away from home, work or significant others for an extended period of time (days or weeks).

6B61.1 Dissociative amnesia without dissociative fugue

- Dissociative amnesia without dissociative fugue is characterized by all the features of dissociative amnesia occurring in the absence of symptoms of dissociative fugue.

6B61.Z Dissociative amnesia, unspecified

Additional clinical features

- In rare cases, amnesia may be generalized with regard to identity and life history. However, it is more commonly localized (i.e. failure to recall autobiographical events during a circumscribed period of time) or selective (i.e. failure to recall some but not all of the events during a circumscribed period of time). The extent of amnesia may vary over time.
- Individuals with dissociative amnesia may only be partly aware of their memory problems. Those who are aware of their memory problems may minimize the importance of these, and may become uncomfortable when prompted to address them.
- Dissociative amnesia is commonly associated with adverse life events, personal or interpersonal conflicts, or stress. The link between the disorder and these events, conflicts and stressors may not be apparent to the individual. Repeated or long-lasting traumatization, trauma caused by multiple perpetrators, and a close relationship with the perpetrator are associated with more persistent and refractory amnesia.
- Dissociative amnesia is commonly associated with chronic difficulty in forming and sustaining satisfying interpersonal relationships. The disorder may also be associated with self-harm, suicide attempts and other high-risk behaviours, depressive symptoms, depersonalization and sexual dysfunctions.

Boundary with normality (threshold)

- Mild difficulties remembering autobiographical events are common, especially as a result of normal ageing. Forgetting early childhood events is also developmentally typical. However, in contrast to dissociative amnesia, normal forgetting:
  - does not typically involve sustained and extensive forgetting of substantial life episodes or significant personal facts;
  - is usually reversed following reminders of forgotten episodes and personal facts;
  - does not have its onset following stressful or traumatic events;
  - does not result in significant impairment in functioning.

Course features

- Onset of dissociative amnesia is typically acute, occurring after traumatic or highly stressful events (e.g. war, natural disaster, maltreatment). Onset may occur immediately after the exposure or after a significant delay.
- Although dissociative amnesia has been observed across the lifespan, it is most commonly diagnosed in patients between 20 and 40 years of age.
- The interval affected by the memory loss and the duration of a given episode of dissociative amnesia are highly variable. In more acute cases, amnesia resolves spontaneously and

rapidly (e.g. after a stressor is resolved), whereas in more chronic cases individuals either regain the ability to recall the dissociated memories slowly or never fully do. Dissociative amnesia with dissociative fugue is associated with a more persistent course.

- Although single episodes of dissociative amnesia have been reported, individuals who have had a single episode of dissociative amnesia may be predisposed to develop subsequent episodes. Most patients experience two or more episodes of dissociative amnesia.
- Post-traumatic stress disorder may develop after memories are regained. In such cases, these memories may be experienced in the form of flashbacks.

Developmental presentations

- Dissociative amnesia can be difficult to detect in young children, whose symptoms may be misinterpreted as lying, denial, inattention, absorption or developmentally appropriate forgetting. Therefore, assessment of amnesia in children should be based on multiple observations or reports from several individuals and types of observers (e.g. parents, teachers, other caregivers).
- Adults are more likely to experience dissociative amnesia with dissociative fugue than children or adolescents.

Culture-related features

- In cultures with strictly defined social role expectations, dissociative amnesia may be associated with severe psychological stresses or conflicts (e.g. marital conflict, other family disturbances, attachment problems, conflicts due to restriction or oppression) rather than with traumatic exposures such as physical or sexual abuse.
- Amnesia reported after culturally accepted religious activities involving dissociative trance or possession should not be diagnosed as dissociative amnesia unless it is in excess of what is considered culturally normative, and is associated with functional impairment.

Sex- and/or gender-related features

- The prevalence of dissociative amnesia is similar among males and females.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with acute stress reaction

Acute stress reaction is a response to an event or situation of an extremely threatening or horrific nature that is considered to be normal given the severity of the stressor. Symptoms of acute stress reaction may include transient amnesia for the immediate period and the event of the stressor. Acute stress reaction begins to subside within a few days after the event or following removal from the threatening situation. Dissociative amnesia should be considered as a diagnosis when the amnesia includes autobiographical information not directly related to the stressor, or when the amnestic episode lasts longer than the immediate aftermath of the stressor (i.e. from several hours to several days).

Boundary with memory deficits in dissociative neurological symptom disorder

Dissociative neurological symptom disorder may include a variety of cognitive symptoms that are not due to the direct effects of a substance or a disease of the nervous system. If cognitive symptoms are focused exclusively on autobiographical memory, dissociative amnesia is the more appropriate diagnosis.

Boundary with possession trance disorder

Amnesia may occur in possession trance disorder. However, amnesia in possession trance disorder is related to episodes experienced as involving the intrusion of a new identity attributed to a spirit, power, deity or other spiritual entity. Possession trance disorder also involves behaviours or movements that are experienced as being controlled by the possessing agent – symptoms that are not typically present in dissociative amnesia.

Boundary with dissociative identity disorder and partial dissociative identity disorder

Episodes of amnesia are common in dissociative identity disorder, and may also occur in partial dissociative identity disorder. However, amnesia in partial dissociative identity disorder is usually brief and restricted to extreme emotional states or episodes of self-harm. Moreover, dissociative amnesia is not characterized by the experience of two or more distinct, alternate personality states, as is the case in dissociative identity disorder and partial dissociative identity disorder. In dissociative amnesia with dissociative fugue, the individual is typically confused about their identity. If two or more distinct personality states recurrently take executive control of the individual's consciousness and functioning, which may include episodes of amnesia, dissociative identity disorder is the more appropriate diagnosis.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

In post-traumatic stress disorder and complex post-traumatic stress disorder, memories of the traumatic event may be fragmented, disorganized or incomplete. When the amnesia is more pervasive and also involves autobiographical memories that are not related to the traumatic event, and the diagnostic requirements of both disorders are met, an additional diagnosis of dissociative amnesia may be assigned.

Boundary with disorders due to substance use

Amnesia is common in disorders due to substance use – particularly alcohol-related disorders (e.g. "alcohol blackouts"). If amnesia occurs exclusively in the context of alcohol or drug use, a diagnosis of dissociative amnesia is not warranted. However, differential diagnosis may be complicated in cases in which an individual with a history of dissociative amnestic episodes also uses alcohol or other substances.

Boundary with memory deficits in neurocognitive disorders, head trauma and medical conditions classified elsewhere

Neurocognitive disorders – including delirium, amnestic disorder and dementia – are characterized by primary acquired clinical deficits in cognitive functioning, frequently including significant and pervasive memory impairment. In neurocognitive disorders, a specific etiological factor or underlying disease process can often be identified. Memory loss may also occur as a result of a brain injury, or as an effect of some diseases of the nervous system or medical conditions classified elsewhere (e.g. a brain tumour). In dissociative amnesia, memory loss is primarily for autobiographical memories, and no underlying disease process or injury that represents a potential etiology for the memory impairment can be identified.

Trance disorder and possession trance disorder

Trance disorder and possession trance disorder are characterized by recurrent or single and prolonged involuntary marked alteration in an individual's state of consciousness involving either a trance state (without possession) or a possession trance state. The distinctive feature of possession trance disorder is that the individual's normal sense of personal identity is replaced by an external "possessing" identity attributed to the influence of a spirit, power, deity or other spiritual entity, which does not occur in trance disorder. In addition, in possession trance disorder a greater range of more complex behaviours may be exhibited, which are experienced as being controlled by the possessing agent, whereas trance disorder typically involves the repetition of a small repertoire of behaviours.

Most trance or possession trance states are brief and transitory, and are related to cultural and religious experiences. These experiences are not considered pathological, and a diagnosis should not be assigned based on their occurrence. Trance and possession trance states should only be considered to be features of a mental disorder when they are involuntary and unwanted, not accepted as a part of a collective cultural or religious practice, and result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Because of the substantial similarity between these disorders, following a separate listing of the essential (required) features of each, the other CDDR elements are provided for the two categories together.

6B62 Trance disorder

Essential (required) features

- Occurrence of a trance state in which there is a marked alteration in the individual's state of consciousness or a loss of the individual's normal sense of personal identity is required for diagnosis, characterized by both:
  - narrowing of awareness of immediate surroundings or unusually narrow and selective focusing on specific environmental stimuli; and
  - restriction of movements, postures and speech to repetition of a small repertoire that is experienced as being outside the individual's control.
  - The trance state is not characterized by the experience of being replaced by an alternate identity.
  - Trance episodes are recurrent or, if the diagnosis is based on a single episode, the episode has lasted for at least several days.
  - The trance state is involuntary and unwanted, and is not accepted as a part of a collective cultural or religious practice.
  - The symptoms are not due to the effects of a substance or medication on the central nervous system (including withdrawal effects), to exhaustion, to hypnagogic or hypnopompic states, or to a disease of the nervous system (e.g. complex partial seizures), head trauma or a sleep-wake disorder.
  - The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6B63 Possession trance disorder

Essential (required) features

- Occurrence of a trance state in which there is a marked alteration in the individual's state of consciousness, and the individual's normal sense of personal identity is replaced by an external "possessing" identity, is required for diagnosis. The trance state is characterized by behaviours or movements that are experienced as being controlled by the possessing agent.
- Trance episodes are attributed to the influence of an external "possessing" spirit, power, deity or other spiritual entity.
- Trance episodes are recurrent or, if the diagnosis is based on a single episode, the episode has lasted for at least several days.
- The possession trance state is involuntary and unwanted, and is not accepted as a part of a collective cultural or religious practice.

- The symptoms are not due to the effects of a substance or medication on the central nervous system (including withdrawal effects), to exhaustion, to hypnagogic or hypnopompic states, or to a disease of the nervous system (e.g. complex partial seizures) or a sleep-wake disorder.
- The symptoms result in significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features for trance disorder and possession trance disorder

- Trance and possession trance disorders tend to involve recurrent episodes rather than a persistent trance or possession trance state. To qualify for a diagnosis, a single, persistent trance or possession trance state must last for at least several days.
- Possession trance disorder is usually characterized by full or partial amnesia for the trance episode. Full or partial amnesia may also occur in trance disorder.
- The actions performed during a trance state (e.g. staring, falling) are generally not complex, whereas during possession trance states the activities performed are often more complex (e.g. coherent conversations, characteristic gestures, facial expressions, specific verbalizations), and are frequently culturally accepted as belonging to a particular possessing agent. These behaviours or movements are often stereotyped, and may reflect cultural influences.
- Presumed possessing agents in possession trance disorder are usually spiritual in nature (e.g. spirits of the dead, gods, demons or other spiritual entities), and are often experienced as making demands or expressing animosity.

Boundary with normality (threshold) for trance disorder and possession trance disorder

- A diagnosis of trance disorder or possession trance disorder should not be applied to experiences that are accepted in the individual's context as collective cultural phenomena or as a part of religious practices. Moreover, the diagnoses should not be applied to trance episodes when these do not result in significant distress or impairment in functioning.
- Single and transitory (minutes to hours) trance or possession trance experiences that are mildly distressing or impairing may occur under stressful circumstances, especially in the context of pre-existing mood disorders or anxiety and fear-related disorders. These single, transitory states are not a sufficient basis for a diagnosis of trance disorder or possession trance disorder.

Course features for trance disorder and possession trance disorder

- Prevalence of trance and possession trance disorders is highest among young adults, with a mean age at onset of between 20 and 25 years.
- The long-term course of trance and possession trance disorders is variable, ranging from a single prolonged episode to multiple recurrences over years.
- Duration and intensity of trance episodes vary considerably. Most recurrent episodes are brief, and individuals may fall in and out of trance states multiple times within a given episode.
- Acute recurrent episodes of trance usually last minutes to hours, and are followed by a period of exhaustion. Episodes of possession trance usually take longer to resolve, with many shifts in and out of trance states over days or even weeks.
- Trance states can be evoked by significant emotional stress, anger or enhanced frustration. Domestic disharmony, war-related trauma and interpersonal conflicts related to religious or cultural issues have also been shown to play a significant role in the precipitation of trance or possession trance states.
- Trance states can occur in clusters (i.e. multiple cases taking place in close temporal and/or spatial proximity), and may be associated with mass suggestibility.
- Individuals with prior exposure to trance states or who are spiritual healers are at higher risk of developing involuntary trance states themselves, outside culturally sanctioned rituals.
- Patients with trance disorder and possession trance disorder often report prodromal symptoms. Somatic complaints and a sense of presence (i.e. feeling that one is not alone) are common. However, presence or absence of prodromal symptoms does not predict the number of trance episodes.
- Possession trance states are often characterized by involuntary motor movements, glossolalia, auditory hallucinations or amnesia. Possession trance states in which the individual's sense of identity is replaced are often preceded by a phase of other, more passive dissociative experiences (e.g. feeling influenced by forces or spirits from the outside, hearing voices, being unable to speak).

Developmental presentations for trance disorder and possession trance disorder

- Trance-like states may manifest in children in various ways, including vacant staring or talking to themselves loudly in different voices.
- Adolescents characterized by nervousness, excitability and emotional instability are more likely to develop trance states.

Cultural presentations for trance disorder and possession trance disorder

- Episodes of trance disorder and possession trance disorder have been documented in a wide range of cultures. Prevalence may increase as part of a collective (mass) response to traumatic events affecting an entire community, such as a measles epidemic. Increases in prevalence have also been attributed to rapid social or cultural change in the affected communities, possibly as an expression of distress and opposition to changing values and circumstances.
- Specific local instances of trance disorder and possession trance disorder show considerable variation cross-culturally regarding the behaviours during the altered state, the presence of dissociative sensory and motor alterations, and the identity assumed during these states. The identities of the possessing agents typically correspond to figures from the religious traditions in the society.
- Some individuals with trance disorder and possession trance disorder may gradually develop control and acceptance of the trance experience, based on participation in religious or cultural groups where these possession trance experiences are normative. Over time, these individuals do not have a higher prevalence of mental disorders than the general population.

Sex- and/or gender-related features for trance disorder and possession trance disorder

- The prevalence of trance disorder and possession trance disorder appears to be comparable among males and females.

Boundaries with other disorders and conditions (differential diagnosis) for trance disorder and possession trance disorder

Boundary with dissociative identity disorder and partial dissociative identity disorder

Possession trance disorder involves a marked alteration in the individual's normal sense of personal identity that is attributed to an external possessing agent. This is distinguished from dissociative identity disorder and partial dissociative identity disorder, which are characterized by the experience of two or more distinct, alternate personality states that are not attributed to an external possessing agent. Individuals describing both internally and externally attributed alternate identities should receive a diagnosis of dissociative identity disorder or partial dissociative identity disorder. In this situation, an additional diagnosis of possession trance disorder should not be assigned.

Boundary with other dissociative disorders

A variety of dissociative symptoms may occur as a part of trance disorder or possession trance disorder, including dissociative amnesia, sensory or motor symptoms, depersonalization and derealization. However, these should not be considered a basis for a separate diagnosis of an additional dissociative disorder when they occur solely during the trance or possession trance state. Symptoms that persist after the trance or possession trance state has ended may be considered a basis for a co-occurring diagnosis of the corresponding dissociative disorder.

Boundary with schizophrenia and other primary psychotic disorders

Intrusive symptoms of possession trance disorder such as hearing voices, insertion of feelings and thoughts, or exhibiting behaviours attributed to the possessing agent are distinguished from symptoms of schizophrenia and other primary psychotic disorders because they occur primarily during the possession trance state, and are usually of brief duration. Possession trance disorder is also distinguished from schizophrenia and schizoaffective disorder by the absence of other types of positive psychotic symptoms or of negative symptoms.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

Post-traumatic stress disorder and complex post-traumatic stress disorder may include flashbacks or other dissociative trance-like states characterized by narrowing of awareness of immediate surroundings and re-experiencing of the traumatic experience as though it were happening again in the here and now. These episodes are generally not experienced as under the person's voluntary control. If trance-like states are limited to episodes of re-experiencing in the context of post-traumatic stress disorder or complex post-traumatic stress disorder, an additional diagnosis of trance disorder should not be assigned.

Boundary with delirium

Delirium and trance disorder may both present with transient and marked alteration in the individual's state of consciousness, but delirium typically presents as significant confusion or global cognitive impairment. In contrast, trance disorder is characterized by a loss of a normal sense of personal identity, narrowing of awareness and restriction of behaviour. Unlike trance disorder, delirium is typically attributable to the direct physiological effects of a medical condition and/or a substance or medication, including withdrawal.

Boundary with epilepsy

Individuals with trance disorder may exhibit features resembling focal unaware (partial complex) seizures, but have normal EEGs even during trance episodes.

6B64 Dissociative identity disorder

Essential (required) features

- Disruption of identity characterized by the presence of two or more distinct personality states (dissociative identities), involving marked discontinuities in the sense of self and agency, is required for diagnosis. Each personality state includes its own pattern of experiencing, perceiving, conceiving and relating to self, the body and the environment.

- At least two distinct personality states recurrently take executive control of the individual's consciousness and functioning in interacting with others or with the environment, such as in the performance of specific aspects of daily life (e.g. parenting, work), or in response to specific situations (e.g. those that are perceived as threatening).
- Changes in personality state are accompanied by related alterations in sensation, perception, affect, cognition, memory, motor control and behaviour. There are typically episodes of amnesia inconsistent with ordinary forgetting, which may be severe.
- The symptoms are not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder).
- The symptoms are not due to the effects of a substance or medication on the central nervous system – including withdrawal effects – (e.g. blackouts or chaotic behaviour during substance intoxication), and are not due to a disease of the nervous system (e.g. complex partial seizures) or to a sleep-wake disorder (e.g. symptoms occur during hypnagogic or hypnopompic states).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- Alternation between distinct personality states is not always associated with amnesia. That is, one personality state may have awareness and recollection of the activities of another personality state during a particular episode. However, substantial episodes of amnesia are typically present at some point during the course of the disorder.
- In individuals with dissociative identity disorder, it is common for one personality state to be "intruded upon" by aspects of other non-dominant, alternate personality states without their taking executive control, as in partial dissociative identity disorder. These intrusions may involve a range of features, including cognitive (intruding thoughts), affective (intruding affects such as fear, anger or shame), perceptual (e.g. intruding voices or fleeting visual perceptions), sensory (e.g. intruding sensations such as being touched, pain or altered perceived size of the body or of part of the body), motor (e.g. involuntary movements of an arm and hand) and behavioural (e.g. an action that lacks a sense of agency or ownership) features. The personality state that is intruded upon in this way commonly experiences the intrusions as aversive, and may or may not realize that the intrusions relate to features of other personality states.
- Dissociative identity disorder is commonly associated with serious or chronic traumatic life events, including physical, sexual or emotional abuse.

Boundary with normality (threshold)

- The presence of two or more distinct personality states does not always indicate the presence of a mental disorder. In certain circumstances (e.g. as experienced by "mediums" or other culturally accepted spiritual practitioners), the presence of multiple personality states is not experienced as aversive, and is not associated with impairment in functioning. A diagnosis of dissociative identity disorder should not be assigned in these cases.

Course features

- Onset of dissociative identity disorder is most commonly associated with traumatic experiences – especially physical, sexual and emotional abuse or childhood neglect. The onset of identity changes can also be triggered by removal from ongoing traumatizing circumstances, by death or serious illness of the perpetrator of abuse, or by other unrelated traumatic experiences later in life.
- Dissociative identity disorder usually has a recurrent and fluctuating clinical course.
- Some individuals remain highly impaired in most aspects of functioning, despite treatment. Individuals with dissociative identity disorder are at high risk of self-injurious behaviour and suicide attempts.
- Although symptoms can remit spontaneously with age, recurrence may occur during periods of increased stress.
- Recurrent or chronic ongoing traumatic experiences are associated with poorer prognosis.
- Dissociative identity disorder often co-occurs with other mental disorders. In such cases, identity alternations can influence the symptom presentation of the co-occurring disorders.

Developmental presentations

- Onset of dissociative identity disorder can occur across the lifespan. Initial identity changes usually appear at an early age, but dissociative identities are not typically fully developed. Instead, children present with discontinuities of experience and marked interference among mental states.
- Identification of dissociative identity disorder in children can be difficult because symptoms manifest in a variety of ways that overlap with other mental disorders, including those involving conduct problems, mood and anxiety symptoms, learning difficulties and auditory hallucinations. Young children often project their dissociated identities onto toys or other objects, so that abnormalities in their identity may only become detectable as children age and their behaviours become less developmentally appropriate. With adequate treatment, children with dissociative identity disorder tend to have a better prognosis than adults.
- Early identity changes in adolescence characteristic of dissociative identity disorder may be mistaken for developmentally typical difficulties with emotional and behavioural regulation.
- Older patients with dissociative identity disorder may present with what appears to be late-life onset paranoia or cognitive impairment, or atypical mood, psychotic or obsessive-compulsive symptoms.

Culture-related features

- Features of dissociative identity disorder can be influenced by the individual's cultural background. For example, individuals may present with dissociative symptoms of movement, behaviour or cognition – such as non-epileptic seizures and convulsions, paralyses or sensory loss – in sociocultural settings where such symptoms are common. These symptoms typically remain persistent and debilitating until the underlying dissociative identity disorder is identified and treated.
- Acculturation or prolonged intercultural contact may shape the characteristics of the dissociative identities; for example, identities in India may speak English exclusively and wear Western clothes as a sign of their difference from the usual personality state.
- In some societies, presentations of dissociative identity disorder may occur after stressful exposures (e.g. recurrent parental affect dysregulation), which may or may not involve physical or sexual abuse. The tendency towards dissociative responses to stressors may be increased in cultures with less individualistic ("bounded") conceptions of the self, or in circumstances of socioeconomic deprivation.

Sex- and/or gender-related features

- Prior to puberty, prevalence of dissociative identity disorder does not appear to vary by gender. After puberty, prevalence appears to be higher among females.
- Significant gender differences have been observed in the symptoms of dissociative identity disorder across the lifespan. Females with dissociative identity disorder often present with more dissociative identities, and tend to experience more acute dissociative states (e.g. amnesia, conversion symptoms, self-mutilation). Males with dissociative identity disorder are more likely to deny their symptoms or to exhibit violent or criminal behaviours.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with trance disorder and possession trance disorder

Trance disorder is not characterized by the presence of two or more distinct personality states. In possession trance disorder, the individual's customary sense of personal identity is replaced by an external "possessing" identity, which is attributed to the influence of a spirit, power, deity or other spiritual entity. Behaviours or movements are experienced as being controlled by the possessing agent. Individuals who describe both internal distinct personality states that assume executive control and episodes of being controlled by an external possessing identity should receive a diagnosis of dissociative identity disorder rather than possession trance disorder.

Boundary with partial dissociative identity disorder

In dissociative identity disorder, discontinuities in agency and sense of self are marked (manifested in episodes of executive control, often including amnesia, and greater elaboration of the personality states), whereas in partial dissociative identity disorder these discontinuities are less pronounced. In partial dissociative identity disorder, one personality state is dominant and functions in daily life (e.g. parenting, work), but is intruded upon by non-dominant personality states (dissociative intrusions). Unlike in dissociative identity disorder, the non-dominant personality states do not recurrently take executive control of the individual's consciousness and functioning to the extent that they perform in specific aspects of daily life (e.g. parenting, work). However, in partial dissociative identity disorder, there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours (e.g. in response to extreme emotional states, episodes of self-harm or the re-enactment of traumatic memories). In partial dissociative identity disorder, the non-dominant personality states are not elaborated to the extent observed in dissociative identity disorder. For example, they may not be oriented to the present, may have the identity of a child, or may be mostly or exclusively involved in re-enacting traumatic memories. In addition, there are typically (although not always) significant episodes of amnesia in dissociative identity disorder, which may be severe. In contrast, episodes of amnesia in partial dissociative identity disorder – if present – are typically brief and restricted to extreme emotional states or episodes of self-harm.

Boundary with other dissociative disorders

Dissociative identity disorder is distinguished from other dissociative disorders by the presence of two distinct personality states that recurrently take executive control of the individual's consciousness and functioning. This does not occur in any other dissociative disorder (except possibly for limited circumstances in partial dissociative identity disorder, as described above). An additional dissociative disorder diagnosis should not be assigned based on phenomena that occur in specific relationship to changes in personality states (e.g. memory loss, changes in motor or sensory functioning, experiences of depersonalization and derealization).

Boundary with schizophrenia and other primary psychotic disorders

Individuals with dissociative identity disorder may report experiencing symptoms such as hearing voices or intrusive thoughts that may also occur in schizophrenia and other primary psychotic disorders. However, individuals with dissociative identity disorder do not typically exhibit delusions, formal thought disorder or negative symptoms (as in schizophrenia or schizoaffective disorder), or rapid-onset and rapidly fluctuating symptoms (as in acute and transient psychotic disorder). In the absence of other symptoms supporting a diagnosis of schizophrenia or another primary psychotic disorder, intrusive phenomena such as hearing voices may suggest the presence of dissociative personality states.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

Individuals with post-traumatic stress disorder and complex post-traumatic stress disorder may experience alterations in identity and sense of agency during episodes of re-experiencing of traumatic events (e.g. during flashbacks). For example, they may feel that they are unable to control their experiences or reactions during the re-experiencing episode, or that they are in a different time in their own lives. However, these episodes are not characterized by a distinct personality state taking executive control of the individual's consciousness and functioning. Because dissociative identity disorder is commonly associated with serious or chronic traumatic life events, it may co-occur with post-traumatic stress disorder or complex post-traumatic stress disorder, and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with obsessive-compulsive disorder

Obsessive-compulsive disorder involves repetitive and persistent thoughts (e.g. of contamination), images (e.g. of violent scenes) or impulses/urges (e.g. to stab someone) that are experienced as intrusive and unwanted (obsessions), as well as repetitive behaviours – including repetitive mental acts – that the individual feels driven to perform (compulsions). However, obsessive-compulsive disorder is not characterized by discontinuities in the sense of self and agency, or the presence of two or more distinct personality states.

Boundary with personality disorder

Personality disorder, particularly with borderline pattern, is characterized by persistent disturbances in sense of identity and self-direction, and often by problems with affect regulation. Personality disorder does not involve the presence of two or more distinct personality states, but some individuals with severe personality disorder exhibit transient dissociative experiences during times of stress or intense emotion.

6B65 Partial dissociative identity disorder

Essential (required) features

- Disruption of identity characterized by the experience of two or more distinct personality states (dissociative identities), involving discontinuities in the sense of self and agency, is required for diagnosis. Each personality state includes its own pattern of experiencing, perceiving, conceiving and relating to self, the body and the environment.
- One personality state is dominant and functions in daily life (e.g. parenting, work), but is intruded upon by one or more non-dominant personality states (dissociative intrusions). These intrusions may be cognitive (intruding thoughts), affective (intruding affects such as fear, anger or shame), perceptual (e.g. intruding voices, fleeting visual perceptions, sensations such as being touched), motor (e.g. involuntary movements of an arm) or behavioural (e.g. an action that lacks a sense of agency or ownership). These experiences are experienced as interfering with the functioning of the dominant personality state and are typically aversive.
- The non-dominant personality states do not recurrently take executive control of the individual's consciousness and functioning to the extent that they perform in specific aspects of daily life (e.g. parenting, work). However, there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours (e.g. in response to extreme emotional states or during episodes of self-harm or the re-enactment of traumatic memories).
- The symptoms are not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder).
- The symptoms are not due to the effects of a substance or medication on the central nervous system – including withdrawal effects – (e.g. blackouts or chaotic behaviour during substance intoxication), and are not due to a disease of the nervous system (e.g. complex partial seizures) or to a sleep-wake disorder (e.g. symptoms occur during hypnagogic or hypnopompic states).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- The dissociative intrusions attributed to non-dominant personality states by individuals with partial dissociative identity disorder are experienced internally, and may not be obvious to observers. Observable identity alteration is typically indicative of dissociative identity disorder.
- Individuals with partial dissociative identity disorder often do not experience amnesia during episodes of dissociative intrusions. If amnesia does occur, it is usually brief and restricted to extreme emotional states or episodes of self-harm.
- Partial dissociative identity disorder is commonly associated with serious or chronic traumatic life events, including physical, sexual or emotional abuse.

Boundary with normality (threshold)

- The presence of distinct personality states or dissociative intrusions does not always indicate the presence of a mental disorder. In certain circumstances (e.g. as experienced by "mediums" or other culturally accepted spiritual practitioners), the presence of multiple personality states is not experienced as aversive and is not associated with impairment in functioning. A diagnosis of partial dissociative identity disorder should not be assigned in these cases.

Course features

- Partial dissociative identity disorder is strongly linked to traumatic experiences – especially physical, sexual and emotional abuse or childhood neglect. The onset of identity changes can also be triggered by removal from ongoing traumatizing circumstances, by death or serious illness of the perpetrator of abuse, or by other unrelated traumatic experiences later in life.
- Partial dissociative identity disorder usually has a recurrent and fluctuating clinical course. Although symptoms might reduce spontaneously with age in older adults, periods of increased stress can cause recurrence of symptoms. Factors such as re-traumatization or chronically ongoing abuse tend to predict a poorer prognosis.
- Partial dissociative identity disorder often co-occurs with other mental disorders. In such cases, identity alternations can influence the symptom presentation of the co-occurring disorders.

Developmental presentations

- Disorganized attachment in childhood might put individuals at risk of developing partial dissociative identity disorder later in life.
- The onset of partial dissociative identity disorder may occur at any stage of life, from early childhood to late adulthood.
- Diagnosis in pre-adolescent children might be particularly challenging, as partial dissociative identity disorder in children can manifest in a variety of ways, including conduct problems, mood and anxiety symptoms, learning difficulties or what appear to be auditory hallucinations. Also, young children often project their dissociated identities onto toys or other objects, so that abnormalities in their identity may become detectable only as children age and their behaviours become less developmentally appropriate. Given adequate treatment, children with partial dissociative identity disorder tend to have a better prognosis than adults.
- Early identity changes in adolescence characteristic of partial dissociative identity disorder may be mistaken for developmentally typical difficulties with emotional and behavioural regulation.
- Older patients with partial dissociative identity disorder may present with what appears to be late-life paranoia, cognitive dysfunction, atypical mood, psychotic symptoms or obsessive-compulsive symptoms.

Culture-related features

- Features of partial dissociative identity disorder can be influenced by the individual's cultural background. For example, individuals may present with dissociative symptoms of movement, behaviour or cognition – such as non-epileptic seizures and convulsions, paralyses or sensory loss – in sociocultural settings where such symptoms are common.
- In some societies, presentations of partial dissociative identity disorder may occur after stressful exposures (e.g. recurrent parental affect dysregulation), which may or may not involve physical or sexual abuse. The tendency towards dissociative responses to stressors may be increased in cultures with less individualistic ("bounded") conceptions of the self, or in circumstances of socioeconomic deprivation.

Sex- and/or gender-related features

- Females appear to be more likely to experience identity intrusions.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with trance disorder and possession trance disorder

Some dissociative intrusions in partial dissociative identity disorder may resemble trance states, but trance disorder is not characterized by the presence of two or more distinct personality states. In possession trance disorder, the individual's normal sense of personal identity is replaced by an external "possessing" identity, which is attributed to the influence of a spirit, power, deity or other spiritual entity. Behaviours or movements are experienced as being controlled by the possessing agent. Individuals who experience dissociative intrusions attributed to both internal and external entities should receive a diagnosis of partial dissociative identity disorder rather than possession trance disorder.

Boundary with dissociative identity disorder

In dissociative identity disorder, discontinuities in agency and sense of self are marked (manifested in episodes of executive control – often including amnesia – and greater elaboration of the personality states), whereas in partial dissociative identity disorder, these discontinuities are less pronounced. In dissociative identity disorder, two or more distinct personality states recurrently take executive control of the individual's consciousness and functioning to the extent that they function in daily life or engage in relatively elaborate patterns of behaviour in specific situations. In contrast, in partial dissociative identity disorder, the non-dominant, alternate personality states do not recurrently take executive control of the individual's consciousness and functioning to the extent that they perform in specific aspects of daily life, although there may be occasional, limited and transient episodes in which a distinct personality state assumes executive control to engage in circumscribed behaviours (e.g. in response to extreme emotional states, episodes of self-harm or the re-enactment of traumatic memories). In partial dissociative identity disorder, the non-dominant alternate personality states are not elaborated to the extent observed in dissociative identity disorder. For example, they may not be oriented to the present, may have the identity of a child, or may be mostly or exclusively involved in re-enacting traumatic memories. Furthermore, in dissociative identity disorder there are typically (although not always) significant episodes of amnesia, which may be severe. In partial dissociative identity disorder, amnesia – if present – is usually brief and restricted to extreme emotional states or episodes of self-harm.

Boundary with other dissociative disorders

Partial dissociative identity disorder is distinguished from other dissociative disorders by the presence of two or more distinct personality states. This does not occur in any other dissociative disorder (except dissociative identity disorder, as described above). An additional dissociative disorder diagnosis should not be assigned based on phenomena that occur in specific relationship to intrusions by non-dominant personality states (e.g. memory loss, changes in motor or sensory functioning, experiences of depersonalization and derealization).

Boundary with schizophrenia and other primary psychotic disorders

Individuals with partial dissociative identity disorder may report experiencing symptoms such as hearing voices or intrusive thoughts that may also occur in schizophrenia and other primary psychotic disorders. However, individuals with partial dissociative identity disorder do not typically exhibit delusions, formal thought disorder or negative symptoms, or rapid-onset and rapidly fluctuating symptoms (as in acute and transient psychotic disorder). In the absence of other symptoms supporting a diagnosis of schizophrenia or another primary psychotic disorder, intrusive phenomena such as hearing voices may suggest the presence of dissociative personality states.

Boundary with obsessive-compulsive disorder

Obsessive-compulsive disorder involves repetitive and persistent thoughts (e.g. of contamination), images (e.g. of violent scenes) or impulses/urges (e.g. to stab someone) that are experienced as intrusive and unwanted (obsessions), as well as repetitive behaviours – including repetitive mental acts that the individual feels driven to perform (compulsions). However, obsessive-compulsive disorder is not characterized by discontinuities in the sense of self and agency, or the presence of two or more distinct personality states.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

Partial dissociative identity disorder involves pervasive alterations in identity and sense of agency. In post-traumatic stress disorder and complex post-traumatic stress disorder, such alterations can occur but are limited to episodes of re-experiencing traumatic events (e.g. during flashbacks). If symptoms consistent with dissociative intrusions occur exclusively during such episodes in the context of post-traumatic stress disorder or complex post-traumatic stress disorder, an additional diagnosis of partial dissociative identity disorder is not warranted.

Boundary with personality disorder

Personality disorder, particularly with borderline pattern, is characterized by persistent disturbances in sense of identity and self-direction, and often by problems with affect regulation. Personality disorder does not involve the presence of two or more distinct personality states, but some individuals with severe personality disorder exhibit transient dissociative experiences during times of stress or intense emotion.

6B66 Depersonalization-derealization disorder

Essential (required) features

- Persistent or recurrent experiences of either depersonalization or derealization, or of both symptoms, are required for diagnosis.
  - *Depersonalization* is characterized by experiencing the self as strange or unreal, or by feeling detached from – or as though one were an outside observer of – one's thoughts, feelings, sensations, body or actions. Depersonalization may take the form of emotional and/or physical numbing, a sense of watching oneself from a distance or "being in a play", or perceptual alterations (e.g. a distorted sense of time).
  - *Derealization* is characterized by experiencing other people, objects or the world as strange or unreal (e.g. dreamlike, distant, foggy, lifeless, colourless or visually distorted), or by feeling detached from one's surroundings.
- During experiences of depersonalization or derealization, reality testing remains intact. The experiences are not associated with delusions or beliefs that the individual is being controlled by external people or forces.
- The symptoms are not better accounted for by another mental disorder (e.g. post-traumatic stress disorder, an anxiety or fear-related disorder, another dissociative disorder, personality disorder).

- The symptoms are not due to the effects of a substance or medication on the central nervous system (including withdrawal effects) and are not due to a disease of the nervous system (e.g. temporal lobe epilepsy), head trauma or another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features

- A common associated symptom in depersonalization-derealization disorder is an altered sense of time, such as the subjective experience of time slowing down or speeding up.
- Catastrophic cognitions (e.g. frequent fears of "going crazy") may occur, along with a lack of vividness in autobiographical memories. Loss of the sense of "ownership" of some memories or physiological hyporeactivity to emotional stimuli may also be present.
- Episodes of depersonalization and derealization in depersonalization-derealization disorder may be associated with adverse life events or interpersonal conflicts.

Boundary with normality (threshold)

- Transient feelings of depersonalization or derealization may be experienced when under stress, during extreme emotional states or exhaustion, when physically ill, or under the influence of substances. Unlike depersonalization-derealization disorder, such experiences typically remit when these emotional or physical states change.

Course features

- Onset of depersonalization-derealization disorder can occur in childhood, but more typically has its onset in mid-adolescence, with a mean age at onset of approximately 16 years. Onset after 25 years of age is very rare.
- The onset of depersonalization-derealization disorder can vary from acute to gradual and insidious, with initial episodes of limited severity and frequency followed by episodes that are more extreme and persistent.
- Discrete episodes of depersonalization-derealization disorder can vary in duration, ranging from brief (e.g. hours or days) to prolonged (e.g. weeks, months or years). The course of the disorder is typically chronic and persistent.
- Most patients experience either continuous symptoms or an initially episodic course that becomes continuous over time. A persistent episodic course is less common, affecting about one third of cases. Intensity of symptoms may differ between episodes or remain constant for years or even decades.

- Internal and external factors such as emotional stress, anxiety or negative affect, sensory overstimulation, sleep deprivation or substance use can exacerbate symptom intensity. Some individuals with depersonalization-derealization disorder report that physical stimulation (e.g. exercise, mild self-injury) or comforting interpersonal interactions can reduce symptom intensity.
- Depersonalization-derealization disorder often co-occurs with mood disorders, anxiety and fear-related disorders or personality disorder. However, co-occurrence of these diagnoses does not appear to alter the severity of depersonalization or derealization symptoms.
- Although a history of verbal or emotional abuse, neglect and other forms of childhood interpersonal trauma are associated with the development of depersonalization-derealization disorder, the association is not as strong as for other dissociative disorders (e.g. dissociative amnesia, dissociative identity disorder). Some cases of depersonalization-derealization disorder develop with what appears to be an onset "out of the blue" that cannot be linked to any identifiable triggers.
- Psychoactive substance use, especially of marijuana or hallucinogens, is a common precipitant of depersonalization and derealization symptoms. However, depersonalization-derealization disorder diagnosis can only be assigned if the symptoms persist beyond the period of intoxication or withdrawal.

Developmental presentations

- Children often have significant difficulty verbalizing their subjective experiences of depersonalization or derealization. They are also less likely than adults to experience unease or distress caused by these symptoms.
- Depersonalization in adolescents may lead to poor academic achievement.

Culture-related features

- Intentionally induced experiences of depersonalization and derealization can be desired objectives of spiritual or meditative practices that are common in many religions and cultures, and should not be assigned a diagnosis of depersonalization-derealization disorder. Transient distressing experiences of depersonalization and derealization may emerge initially during these practices, but abate as the person acquires proficiency.
- However, some individuals who initially induce these states intentionally or experience them as part of their religious practice may lose control over them and develop persistent symptoms that warrant assigning the diagnosis.

Sex- and/or gender-related features

- Depersonalization-derealization disorder occurs with similar frequency among men and women, with similar clinical characteristics.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with other dissociative disorders

Experiences of depersonalization and derealization are common in other dissociative disorders – particularly dissociative identity disorder, partial dissociative identity disorder, trance disorder and possession trance disorder. If the diagnostic requirements for another dissociative disorder are met, an additional diagnosis of depersonalization-derealization disorder should not be assigned.

Boundary with schizophrenia and other primary psychotic disorders

In schizophrenia and other primary psychotic disorders, non-transient experiences of depersonalization or derealization are common during psychotic episodes, and may be accompanied by delusional interpretations of this experience. If depersonalization and/or derealization are limited to periods of psychotic symptoms in an individual with schizophrenia or another primary psychotic disorder, an additional diagnosis of depersonalization-derealization disorder should not be assigned.

Boundary with depressive disorders

Depersonalization and derealization are common during depressive episodes, and may be persistent. An additional diagnosis of depersonalization-derealization disorder should not be assigned if the symptoms occur only during depressive episodes, or are otherwise better accounted for by a depressive disorder.

Boundary with panic attacks

Panic attacks in the context of panic disorder or other mental disorders may be associated with marked experiences of depersonalization-derealization, which may persist for a time after the panic episode subsides. If depersonalization-derealization symptoms occur exclusively during panic attacks or continue only for a brief period afterwards, a separate diagnosis of depersonalization-derealization disorder is not warranted.

Boundary with other anxiety and fear-related disorders

Transient experiences of depersonalization or derealization are also common in other anxiety and fear-related disorders such as social anxiety disorder and generalized anxiety disorder. If depersonalization and/or derealization is better accounted for by an anxiety or fear-related disorder (for example, these experiences occur only in the context of confrontation with the corresponding focus of apprehension), an additional diagnosis of depersonalization-derealization disorder should not be assigned.

Boundary with post-traumatic stress disorder and complex post-traumatic stress disorder

Experiences of depersonalization and derealization are common in post-traumatic stress disorder, particularly during re-experiencing episodes such as flashbacks. If depersonalization or derealization is limited to episodes of re-experiencing in an individual with post-traumatic stress disorder or complex post-traumatic stress disorder, an additional diagnosis of depersonalization-derealization disorder should not be assigned. However, if clinically significant depersonalization and derealization occurs outside or is persistent following re-experiencing episodes, and the diagnostic requirements of both disorders are met, an additional diagnosis of depersonalization-derealization disorder may be assigned.

Boundary with personality disorder

Experiences of depersonalization or derealization may occur in personality disorder, especially when the person is under stress. If the symptoms are better accounted for by personality disorder, an additional diagnosis of depersonalization-derealization disorder should not be assigned.

6B6Y Other specified dissociative disorder

Essential (required) features

- The presentation is characterized by symptoms that share primary clinical features with other dissociative disorders (i.e. involuntary disruption or discontinuity in the normal integration of one or more of the following: identity, sensations, perceptions, affects, thoughts, memories, control over bodily movements or behaviour).
- The symptoms do not fulfil the diagnostic requirements of any of the other disorders in the grouping of dissociative disorders.
- The symptoms are not better accounted for by another mental disorder (e.g. post-traumatic stress disorder, complex post-traumatic stress disorder, schizophrenia, bipolar disorders).
- The symptoms are involuntary and unwanted, and are not accepted as a part of a collective cultural or religious practice.
- The symptoms are not due to the effects of a substance or medication on the central nervous system – including withdrawal effects – (e.g. blackouts or chaotic behaviour during substance intoxication), and are not due to a disease of the nervous system (e.g. complex partial seizures), a sleep-wake disorder (e.g. symptoms occur during hypnagogic or hypnopompic states), head trauma or another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

6B6Z Dissociative disorder, unspecified

Feeding and eating disorders

Feeding and eating disorders involve abnormal eating or feeding behaviours that are not better accounted for by another medical condition, and are not developmentally appropriate or culturally sanctioned. Feeding disorders involve behavioural disturbances that are not related to body weight or shape concerns, such as eating of non-edible substances or voluntary regurgitation of foods. Eating disorders involve abnormal eating behaviour and preoccupation with food, accompanied in most instances by prominent body weight or shape concerns.

Feeding and eating disorders include the following:

- **6B80** Anorexia nervosa
- **6B81** Bulimia nervosa
- **6B82** Binge-eating disorder
- **6B83** Avoidant-restrictive food intake disorder
- **6B84** Pica
- **6B85** Rumination-regurgitation disorder
- **6B8Y** Other specified feeding or eating disorder
- **6B8Z** Feeding or eating disorder, unspecified.

Feeding and eating disorder diagnoses should not be used to classify low-level concerns related to eating or behaviours that are common or culturally sanctioned.

General cultural considerations for feeding and eating disorders

- Weight and shape concerns are prevalent in many societies, and dieting to lose weight is common. Cultural preoccupation with body weight and shape – for example, due to global dissemination of body ideals through mass media (typically low weight in women and muscular physique in men) – has contributed to increased rates of eating disorders in many parts of the world. The global obesity epidemic has also contributed to social concerns about eating and weight.
- The prevalence of feeding and eating disorders varies by region, including differences by gender. For example, weight concerns and eating disturbances are more prevalent among men in some Asian and eastern Mediterranean societies than in the Americas.

6B80 Anorexia nervosa

Essential (required) features

- Significantly low body weight for the individual's height, age, developmental stage or weight history is required for diagnosis. A commonly used threshold is body mass index (BMI) of less than 18.5 kg/m^2 in adults and BMI for age under the 5th percentile in children and adolescents. Rapid weight loss (e.g. more than 20% of total body weight within 6 months) may replace the essential feature of low body weight, as long as other diagnostic requirements are met. Children and adolescents may exhibit failure to gain weight as expected based on the individual developmental trajectory rather than weight loss.
- Low body weight is not better accounted for by another medical condition or the unavailability of food.
- The presentation is characterized by a persistent pattern of restrictive eating or other behaviours aimed at establishing or maintaining abnormally low body weight, typically associated with extreme fear of weight gain. Behaviours may be aimed at reducing energy intake by fasting, choosing low-calorie food, excessively slow eating of small amounts of food, and hiding or spitting out food, as well as by purging behaviours such as self-induced vomiting and use of laxatives, diuretics or enemas, or omission of insulin doses in individuals with diabetes. Behaviours may also be aimed at increasing energy expenditure through excessive exercise, motor hyperactivity, deliberate exposure to cold and use of medication that increases energy expenditure (e.g. stimulants, weight-loss medication, herbal products for reducing weight, thyroid hormones).
- Excessive preoccupation with body weight or shape is apparent. Low body weight is overvalued and central to the person's self-evaluation, or the person's body weight or shape is inaccurately perceived to be normal or even excessive. Preoccupation with weight or shape, when not explicitly reported, may be manifested in behaviours such as repeatedly checking body weight using scales; repeatedly checking body shape using tape measures or reflection in mirrors; constantly monitoring the calorie content of food or searching for

information on how to lose weight; or exhibiting extreme avoidant behaviours, such as refusal to have mirrors at home, avoidance of tight-fitting clothes, or refusal to know one's weight or to purchase clothing with specified sizing.

Specifiers for underweight status

In the context of anorexia nervosa, severe underweight status is an important prognostic factor that is associated with a high risk of physical complications and substantially increased mortality. In adults, very low BMI has been found to be associated with poorer long-term prognosis among individuals with anorexia nervosa, although it is not the sole determinant of medical risk.

6B80.0 Anorexia nervosa with significantly low body weight

- Anorexia nervosa with significantly low body weight meets all diagnostic requirements for anorexia nervosa, with BMI between 18.5 kg/m^2 and 14.0 kg/m^2 in adults or BMI for age between the 5th and 0.3rd percentile in children and adolescents.

6B80.1 Anorexia nervosa with dangerously low body weight

- Anorexia nervosa with dangerously low body weight meets all diagnostic requirements for anorexia nervosa, with BMI of under 14.0 kg/m^2 in adults or BMI for age under the 0.3rd percentile (fewer than three in one thousand) in children and adolescents. In the context of anorexia nervosa, dangerously low body weight is an important prognostic factor that is associated with a high risk of physical complications and substantially increased mortality.

6B80.2 Anorexia nervosa in recovery with normal body weight

- Among individuals who are recovering from anorexia nervosa who have achieved a healthy body weight, the diagnosis should be retained until a full and lasting recovery is achieved. A full and lasting recovery includes maintenance of a healthy weight and the cessation of behaviours aimed at reducing body weight for a sustained period (e.g. at least 1 year) following the termination of treatment.

6B80.Y Other specified anorexia nervosa

6B80.Z Anorexia nervosa, unspecified

Specifiers for the pattern of weight-related behaviours

Different patterns of weight-related behaviours among individuals with anorexia nervosa may be related to treatment selection and clinical management, as well as the course and outcome of the disorder. The following specifiers may be applied to 6B80.0 Anorexia nervosa with significantly low body weight and 6B80.1 Anorexia nervosa with dangerously low body weight. (The *x* below corresponds to the fifth-character code 0 or 1, indicating the individual's underweight status.)

6B80.*x*0 restricting pattern

The *restricting pattern* specifier should be assigned to individuals with anorexia nervosa who induce weight loss and maintain low body weight through restricted food intake or fasting, alone or in combination with increased energy expenditure (e.g. through excessive exercise), but who do not engage in binge-eating or purging behaviours.

6B80.*x*1 binge-purge pattern

The *binge-purge pattern* specifier should be assigned to individuals with anorexia nervosa who present with episodes of binge-eating or purging behaviours aimed at getting rid of ingested food (e.g. self-induced vomiting, laxative abuse or enemas). This type of anorexia nervosa also includes individuals who exhibit binge-eating episodes but do not purge.

6B80.*x*Z unspecified

Additional clinical features

- Signs of low body weight may include visible or measurable signs of starvation, such as emaciation (lack of fat and muscle mass), extremities that feel cold to the touch or appear blue, hair loss, growth of fine "lanugo" hair, oedema, proximal muscle weakness, amenorrhea, osteopenia or osteoporosis, slow heart rate and low blood pressure.
- An explicitly stated fear of weight gain is not an absolute requirement for the diagnosis of anorexia nervosa, as long as the behaviours maintaining underweight status appear to be intentional, and there are other behavioural indicators of preoccupation with body weight or shape (e.g. repeated checking or monitoring, or extreme avoidance behaviours).
- Individuals with anorexia nervosa often show a persistent lack of recognition that they are underweight or excessively thin, and dismiss objective evidence regarding their actual weight or shape and the seriousness of their condition.
- Medical risk among individuals with anorexia nervosa is not solely dependent on weight status. Medical assessment should take into account other important medical risk factors as part of a comprehensive physical examination. Other risk factors include, but are not limited to, rapid weight loss (especially in children), orthostatic hypotension, bradycardia or postural tachycardia, hypothermia, cardiac arrhythmia and biochemical disturbance.

Boundary with normality (threshold)

- Anorexia nervosa must be associated with significantly low body weight for the individual's height, age, developmental stage or weight history, and with extreme attitudes and behaviours that distinguish it from normal dieting and "normative discontent" with one's body shape and weight.

Course features

- Anorexia nervosa often has its onset during adolescence or early adulthood (i.e. between the ages of 10 and 24 years), typically following a stressful life event. Early-onset anorexia nervosa (prior to puberty) and late-onset anorexia nervosa (after the age of 40 years) are relatively rare.
- Many individuals display a period of altered eating behaviours prior to meeting the full diagnostic requirements for anorexia nervosa.
- Although some individuals recover fully after a single episode of anorexia nervosa, many experience a chronic course of illness over many years.
- Individuals with severe symptoms of anorexia nervosa may require hospitalization to restore weight and address medical complications. These individuals are less likely to experience remission of symptoms.
- Most individuals diagnosed with anorexia nervosa experience remission within 5 years of onset. However, even after an individual no longer meets the diagnostic requirements for anorexia nervosa, they are more likely to have a lower body weight and increased psychological features associated with anorexia nervosa (e.g. perfectionism) compared to the general population.
- Anorexia nervosa is associated with premature death, often due to medical complications of starvation or to suicide.

Developmental presentations

- Children with anorexia nervosa may not be able to articulate body-image concerns and emotions related to restrictive eating. Presenting features among children may include avoidance of food intake with denial of the severity of malnutrition for reasons other than body-image concerns (e.g. reporting they are "not hungry" or have abdominal pain), as well as nonverbal forms of food refusal.
- Children with anorexia nervosa are less likely to engage in binge eating and purging, or to engage in other compensatory behaviours.
- The prognosis for adolescents diagnosed with anorexia nervosa is better than the prognosis for adults with anorexia nervosa.

- Older individuals with anorexia nervosa who have had a longer duration of illness often exhibit chronic medical complications.

Culture-related features

- Symptom presentation of anorexia nervosa varies across cultural groups. For example, in Asia, a subset of individuals with anorexia nervosa may not express fear of weight gain (sometimes referred to as "fat phobia") as a rationale for reducing energy intake. Instead, dietary restriction may be attributed to gastrointestinal discomfort or to cultural or religious motives (fasting or dietary rules). Such cases should still be regarded as meeting the excessive preoccupation with body weight or shape essential feature if clinical observation or collateral history supports the conclusion that they are motivated by an intention to lose weight or to prevent weight gain.
- Anorexia nervosa occurs in all cultures, but cross-cultural variations exist in prevalence and presentation. For example, the incidence of anorexia nervosa is greater in high-income countries and in populations with higher levels of globalization and related transformations in sociocultural values, gender roles, work, food supply and lifestyle. The prevalence of anorexia nervosa is very low in Africa and Latin America, and among African Americans and Latin Americans in the United States compared to the prevalence found in Europe and some Asian countries, such as China and Japan.
- The prevalence of anorexia nervosa among men is increasing globally, and more men are presenting for treatment of the disorder.

Sex- and/or gender-related features

- Globally, anorexia nervosa is up to 10 times more commonly diagnosed among females. Lifetime prevalence among women has been reported to be between 0.8% and 6.3% in Western settings. Emerging studies from eastern Europe, Asia and Latin America show a similar range of prevalence.
- Less is known about the true prevalence of anorexia nervosa in males. However, there is evidence that incidence and detection of anorexia nervosa in males is increasing.
- The onset of anorexia nervosa is earlier in females.
- Laxative abuse is more common among females; excessive exercise is more common among males.
- Males with anorexia nervosa are more likely to be preoccupied with being insufficiently muscular or lean – in response, they may exhibit unusual eating behaviours (e.g. excessive protein consumption along with caloric restriction) or engage in excessive exercise for the purpose of attaining and maintaining low body weight or a low percentage of body fat. If low body weight and low body weight idealization are not part of the clinical presentation, a diagnosis of body dysmorphic disorder should be considered (see the section *on boundaries with other disorders and conditions (differential diagnosis)* below).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with bulimia nervosa

Individuals with anorexia nervosa may engage in binge eating and purging, but can be distinguished from individuals with bulimia nervosa by their very low body weight. A significant proportion of individuals with anorexia nervosa continue to exhibit binging and/or purging symptoms after they have regained a more normal weight. In such cases, the diagnosis may be changed to bulimia nervosa after 1 year during which body weight has not been sufficiently low to meet the diagnostic requirements of anorexia nervosa.

Boundary with avoidant-restrictive food intake disorder

Behaviours to establish or maintain an abnormally low body weight in anorexia nervosa are usually explicitly motivated by a desire for thinness or an intense fear of gaining weight. However, other rationales for disturbances in eating behaviours or weight loss in anorexia nervosa may be given, such as fear of physical discomfort (e.g. stomach bloating), self-punishment, or religious or moral reasons. In cases in which the individual otherwise meets the diagnostic requirements of anorexia nervosa but weight- or shape-related concerns are not explicitly endorsed, the altered eating behaviours should only be considered as diagnostic of anorexia nervosa if clinical observation or collateral history supports the conclusion that they are motivated by an intention to lose weight or to prevent weight gain. When such individuals begin to alter their eating behaviours and to gain weight, often as a result of treatment, it is common for more explicit weight- or shape-related concerns to emerge. In cases where concerns about body weight or shape continue to be absent in spite of alteration of eating behaviours and weight gain, it is generally more appropriate to change the diagnosis to avoidant-restrictive food intake disorder.

Boundary with schizophrenia and other primary psychotic disorders

Beliefs that may be considered unusual, are demonstrably untrue, or even appear to be delusional in intensity or fixity may be present in individuals with anorexia nervosa, but these are generally restricted to issues of food, weight and shape, and are otherwise consistent with the psychopathology of anorexia nervosa. Examples include a conviction that one is fat when one is demonstrably underweight, or a belief that one's caloric intake is excessive when it is in fact insufficient to maintain a normal weight. Such beliefs are consistent with a diagnosis of anorexia nervosa, and an additional diagnosis of delusional disorder or other psychotic disorder is not warranted in such cases. However, if other delusional beliefs are present (e.g. persecutory delusions that are unrelated to weight, shape or food intake) or there are other psychotic symptoms (e.g. thought disorder, hallucinations), a separate diagnosis of a primary psychotic disorder may be warranted.

Boundary with obsessive-compulsive disorder

Individuals with anorexia nervosa often experience repetitive and persistent thoughts about their weight or shape or about food, which can resemble obsessions. They may also engage in repetitive behaviours in response to these thoughts (e.g. exercise, purging). If repetitive thoughts and behaviours are limited to concerns about weight or shape or about food, an additional diagnosis of obsessive-compulsive disorder should not be assigned.

Boundary with body dysmorphic disorder

Body dysmorphic disorder is distinguished from anorexia nervosa in that preoccupations and body-image disturbance in body dysmorphic disorder are focused on features other than overall

weight, shape and size (e.g. preoccupation with the nose or skin), and are not accompanied by disturbance in eating behaviour or marked weight loss. Some individuals (primarily males) with body dysmorphic disorder exhibit muscle dysmorphia such that they are preoccupied about being insufficiently muscular or lean and, in response, may exhibit unusual eating behaviours (e.g. excessive protein consumption) or engage in excessive exercise (e.g. weightlifting). In these cases, behaviours related to diet and exercise are motivated by a desire to be more muscular rather than to attain or maintain a low body weight. However, if low body weight idealization is central to the clinical presentation, and body weight is sufficiently low, a diagnosis of anorexia nervosa instead of body dysmorphic disorder should be assigned.

6B81 Bulimia nervosa

Essential (required) features

- Frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of at least 1 month) are required for diagnosis. Binge eating is defined as a discrete period of time (e.g. 2 hours) during which the individual experiences a loss of control over their eating behaviour, and eats notably more or differently than usual. Loss of control over eating may be described by the individual as feeling like they cannot stop or limit the amount or type of food eaten; having difficulty stopping eating once they have started; or giving up even trying to control their eating because they know they will end up overeating.
- The presentation is characterized by repeated inappropriate compensatory behaviours to prevent weight gain (e.g. once a week or more over a period of at least 1 month). The most common compensatory behaviour is self-induced vomiting, which typically occurs within an hour of binge eating. Other inappropriate compensatory behaviours include fasting or using diuretics to induce weight loss, using laxatives or enemas to reduce the absorption of food, omission of insulin doses in individuals with diabetes, and strenuous exercise to greatly increase energy expenditure.
- Excessive preoccupation with body weight or shape is apparent. Preoccupation with weight or shape, when not explicitly reported, may be manifested in behaviours such as repeatedly checking body weight using scales; repeatedly checking body shape using tape measures or reflection in mirrors; constantly monitoring the calorie content of food or searching for information on how to lose weight; or exhibiting extreme avoidant behaviours, such as refusal to have mirrors at home, avoidance of tight-fitting clothes, or refusal to know one's weight or to purchase clothing with specified sizing.
- There is marked distress about the pattern of binge eating and inappropriate compensatory behaviour, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. During the early phases of the disorder, symptoms may be concealed and functioning maintained through significant additional effort.
- The symptoms do not meet the diagnostic requirements for anorexia nervosa.

Additional clinical features

- Binge-eating episodes may be "objective", in which the individual eats an amount of food that is larger than what most people would eat under similar circumstances, or "subjective", which may involve eating amounts of food that might be objectively considered to be within normal limits but are subjectively experienced as large by the individual. In either case, the core feature of a binge-eating episode is the experience of loss of control over eating.
- Additional characteristics of binge-eating episodes may include eating much more rapidly than usual, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, or eating alone because of embarrassment.
- Binge eating is typically experienced as very distressing. This is often manifested in negative emotions such as guilt, disgust or shame, which also typically negatively affect the individual's self-evaluation.
- Bulimia nervosa may be associated with weight gain over time. However, individuals with bulimia nervosa may be of normal weight or even low weight (although not sufficiently low to meet the diagnostic requirements for anorexia nervosa). The diagnosis of bulimia nervosa is based on the presence of regular binge eating and inappropriate compensatory behaviours, regardless of overweight status.

Boundary with normality (threshold)

- Infrequent overeating or feasting during culturally sanctioned holidays or occasional celebrations should not be characterized as binge eating for the purpose of assigning a diagnosis of bulimia nervosa. Similarly, exercise qualifies as *inappropriate* compensatory behaviour only if it is unusually intensive or prolonged, or is carried out to the exclusion of other activities or in spite of fatigue, pain or injury.

Course features

- Like anorexia nervosa, bulimia nervosa most commonly has its onset during the period from adolescence to early adulthood (i.e. between the ages of 10 and 24 years), typically following a stressful life event. Onset prior to puberty or after the age of 40 years is relatively rare.
- Bulimia nervosa is characterized by a variable course that can manifest as persistent symptoms or intermittent episodes of remission and exacerbation. Outcome appears to be related to course, such that individuals whose symptoms remit for a period longer than 1 year tend not to experience relapse of the disorder.

- Individuals with bulimia nervosa are at a significantly increased risk of substance use, suicidality and health complications (e.g. gastrointestinal problems) that can lead to premature death.
- Some individuals may cease purging or compensatory behaviours but continue to engage in binge eating. In this case, the diagnosis may be changed to binge-eating disorder if all diagnostic requirements are met.
- Stressful life events or a history of anorexia nervosa increase the likelihood of the onset of bulimia nervosa. A restricting pattern in anorexia nervosa may evolve over time into a pattern of binging and purging in bulimia nervosa. In such cases, the diagnosis may be changed to bulimia nervosa after 1 year during which body weight has not been sufficiently low to meet the diagnostic requirements of anorexia nervosa.

Developmental presentations

- Onset of bulimia nervosa typically occurs during or shortly after puberty. Young children do not commonly engage in binge eating due to a lack of access and control of food availability.

Culture-related features

- The prevalence of bulimia nervosa is higher in cultures characterized by an idealized thin body ideal. In addition, the prevalence of bulimia nervosa is increasing in countries that are industrializing and transitioning to more global and urbanized societies.
- The distribution of bulimia nervosa across cultural groups within a society can change over time. For example, in the United States, the incidence of the disorder appears to be decreasing among Euro-American females and increasing among ethnic minority groups – particularly Latin Americans and African Americans.
- Purging methods may be locally specific, such as the use of herbal purgatives in Asia and the Pacific region (e.g. seaweed and herbal teas in Japan; indigenous tea in Fiji), and justified with medicinal or other rationales that may obscure their pathological significance.

Sex- and/or gender-related features

- Bulimia nervosa is more prevalent among females.
- Males are less likely than females to engage in purging behaviours, and have a greater tendency to use excessive exercise or steroids as compensatory behaviours in response to binges. Males are also less likely to seek treatment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with anorexia nervosa

Individuals with anorexia nervosa may engage in binge eating and purging, but can be distinguished from individuals with bulimia nervosa by their very low body weight. If binge eating and purging are associated with very low body weight (i.e. BMI of less than 18.5 kg/m^2 in adults and BMI for age under the 5th percentile in children and adolescents), and all the other diagnostic requirements are met, a diagnosis of anorexia nervosa, binge-purge pattern, rather than bulimia nervosa should be assigned. Moreover, a significant proportion of individuals with anorexia nervosa continue to exhibit binging or purging behaviours after they have regained a more normal weight. In such cases, the diagnosis may be changed to bulimia nervosa after 1 year during which body weight has not been sufficiently low to meet the diagnostic requirements of anorexia nervosa.

Boundary with binge-eating disorder

Binge eating that is not associated with regular compensatory behaviours should be diagnosed as binge-eating disorder rather than bulimia nervosa.

6B82 Binge-eating disorder

Essential (required) features

- Frequent, recurrent episodes of binge eating (e.g. once a week or more over a period of 3 months) are required for diagnosis. Binge eating is defined as a discrete period of time (e.g. 2 hours) during which the individual experiences a loss of control over their eating behaviour and eats notably more or differently than usual. Loss of control over eating may be described by the individual as feeling like they cannot stop or limit the amount or type of food eaten; having difficulty stopping eating once they have started; or giving up even trying to control their eating because they know they will end up overeating.
- The binge-eating episodes are not regularly accompanied by inappropriate compensatory behaviours aimed at preventing weight gain.
- The symptoms and behaviours are not better accounted for by another medical condition (e.g. Prader-Willi syndrome) or mental disorder (e.g. a depressive disorder), and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- There is marked distress about the pattern of binge eating, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. During the earlier phases of the disorder, symptoms may be concealed and functioning maintained through significant additional effort.

Additional clinical features

- Binge-eating episodes may be "objective", in which the individual eats an amount of food that is larger than most people would eat under similar circumstances, or "subjective", which may involve eating amounts of food that might be objectively considered to be within normal limits but are subjectively experienced as large by the individual. In either case, the core feature of a binge-eating episode is the experience of loss of control over eating.
- Additional characteristics of binge-eating episodes may include eating much more rapidly than usual, eating until feeling uncomfortably full, eating large amounts of food when not feeling physically hungry, or eating alone because of embarrassment.
- Binge eating is typically experienced as very distressing. This is often manifested in negative emotions such as guilt, disgust or shame, which also typically negatively affect the individual's self-evaluation.
- When there are multiple binge-eating episodes per week and these are associated with significant distress, it may be appropriate to assign the diagnosis after a shorter period (e.g. 1 month).
- Binge-eating disorder is often associated with weight gain over time and obesity. However, individuals with binge-eating disorder may be of normal weight or even low weight (although not sufficiently to meet the diagnostic requirements for anorexia nervosa). The diagnosis of binge-eating disorder is based on the presence of regular binge eating that is not accompanied by regular inappropriate compensatory behaviours, regardless of overweight status.
- Preoccupation with one's body weight or shape, frequent checking or avoidance of checking body weight or size, and strong influence of body weight or shape on self-evaluation are commonly present, although not required for a diagnosis of binge-eating disorder.

Boundary with normality (threshold)

- Infrequent overeating or feasting during culturally sanctioned holidays or occasional celebrations should not be characterized as binge eating for the purpose of assigning a diagnosis of binge-eating disorder.
- Individuals who report patterns of overeating that do not meet the definition of binge eating should not be diagnosed with binge-eating disorder. Examples include mindless eating that can be resisted or stopped (e.g. if there is a distraction or interruption), or eating more than originally intended without a sense of loss of control, even if this kind of eating is distressing.

Course features

- Onset of binge-eating disorder is typically during adolescence or young adulthood, but can also begin in later adulthood.
- The experience of loss of control over eating or sporadic episodes of binge eating may occur prior to the onset of binge-eating disorder.
- Binge-eating disorder is more common among individuals seeking weight-loss treatment. Typically, these individuals seek weight-loss treatment after the onset of the disorder; binge eating does not typically arise as a consequence of treatment.
- Binge-eating disorder occurs more often among overweight and obese individuals than those with normal BMI.
- Individuals who seek treatment for binge-eating disorder are typically older in age compared to individuals who seek treatment for other feeding and eating disorders.
- Binge-eating disorder, although often persistent, has a higher rate of remission than other feeding and eating disorders, with remission sometimes occurring spontaneously.
- The features of binge-eating disorder may evolve over time, such that another feeding or eating disorder may better characterize the current symptoms.

Developmental presentations

- In children, as in adults, binge-eating disorder is associated with weight gain, increased body fat, concealing one's eating and use of binge eating to regulate emotions.
- Binge-eating disorder is more difficult to diagnose in childhood due to normative difficulty engaging in introspection in order to articulate reasons for binge-eating behaviour. Children are likely to report feeling out of control while eating rather than indicating that the amount of food consumed was excessive.
- Children with binge-eating disorder may experience less frequent and briefer binges than adults because they typically cannot gain access to food without the assistance of adults.
- Binge-eating disorder is common among adolescents and young adults.

Culture-related features

- Compared to other feeding and eating disorders, binge-eating disorder appears to be more equally distributed across countries, ethnic groups and genders. The prevalence of binge-eating disorder is at least as high in low- and middle-income countries as across high-income countries, and tends to correlate with rise of BMI in the general population.

- The relationship between ideal body size, body satisfaction and binge-eating disorder is complex. For example, women who report strong identification with African American or Black Caribbean culture also tend to report larger body ideals and higher body satisfaction, yet tend to have elevated rates of binge eating.

Sex- and/or gender-related features

- Binge-eating disorder is more prevalent among females.
- There are no significant gender-related differences in the symptoms or course of binge-eating disorder.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with bulimia nervosa

If an individual regularly engages in inappropriate compensatory behaviours following episodes of binge eating (e.g. self-induced vomiting, use of laxatives, enemas, diuretics, fasting, strenuous exercise or omitting insulin), a diagnosis of bulimia nervosa rather than binge-eating disorder should be assigned.

Boundary with obesity

Obesity is a common consequence of binge-eating disorder and should be recorded separately. However, obese individuals who report overeating patterns that do not meet the definition of binge eating should not be diagnosed with binge-eating disorder.

6B83 Avoidant-restrictive food intake disorder

Essential (required) features

- Avoidance or restriction of food intake is required for diagnosis, which results in either or both of the following:
  - the intake of an insufficient quantity or variety of food to meet adequate energy or nutritional requirements that has resulted in significant weight loss, clinically significant nutritional deficiencies, dependence on oral nutritional supplements or tube feeding, or has otherwise negatively affected the physical health of the individual;
  - significant impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. due to avoidance or distress related to participating in social experiences involving eating).

- The pattern of eating behaviour is not motivated by preoccupation with body weight or shape.
- Restricted food intake and consequent weight loss (or failure to gain weight), or other impacts on physical health or related functional impairment, are not due to unavailability of food; are not a manifestation of another medical condition (e.g. food allergies, hyperthyroidism) or mental disorder; and are not due to the effects of a substance or medication, including withdrawal effects.

Additional clinical features

- A variety of reasons may be given for restriction of food intake, such as lack of interest in eating, avoidance of foods with certain sensory characteristics (e.g. smell, taste, appearance, texture, colour, temperature) or concern about perceived aversive consequences of eating (e.g. choking, vomiting, health problems), which in some cases is related to a history of aversive food-related experience such as choking or vomiting after eating a particular type of food. In many cases, however, there is no identifiable event that preceded the onset of the disorder.
- Some individuals with avoidant-restrictive food intake disorder present with a longstanding lack of interest in food or eating, chronically low appetite or poor ability to recognize hunger. In other cases, restriction of food intake may be more variable and significantly affected by emotional or psychological factors. This latter pattern may be associated with high levels of distractibility or with high levels of emotional arousal and extreme resistance in situations in which eating is expected. Individuals with this pattern, especially children, often require significant prompting and encouragement to eat.
- Individuals with avoidant-restrictive food intake disorder generally do not experience any difficulties eating foods within their preferred range, and may therefore not be underweight.
- Avoidant-restrictive food intake disorder can negatively affect family functioning, such that mealtimes may be associated with increased distress (e.g. infants may be more irritable during feeding, children may try to negotiate what food is present or how much they need to consume at mealtimes).

Boundary with normality (threshold)

- People with unusual patterns of eating behaviour or who are exceptionally "picky eaters" should not be diagnosed with avoidant-restrictive food intake disorder in the absence of significant weight loss or other health consequences (e.g. clinically significant nutritional deficiencies, increases in blood lipids due to selective eating of fatty foods) or impairment in psychosocial functioning (e.g. limited participation in social activities where preferred foods are not available). Distress on the part of parents or other caregivers related to selective eating in the absence of identifiable health consequences or impairment in the individual's functioning is not a basis for assigning the diagnosis.

- Avoidance of specific foods or limitation of food intake due to religious or other culturally sanctioned practices does not meet the diagnostic requirements of avoidant-restrictive food intake disorder unless the pattern of restricted food intake has negatively affected the physical health of the individual or resulted in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Course features

- Avoidant-restrictive food intake disorder may be associated with delays in typical development (e.g. growth, learning), particularly if significant malnutrition is present.
- Among individuals with avoidant-restrictive food intake disorder, avoidant and restrictive patterns of eating may persist into adulthood.
- Individuals with avoidant-restrictive food intake disorder may develop certain features of anorexia nervosa over time (e.g. concerns about body weight or negative attitudes about fatness), but do not typically develop the body image distortion commonly seen in anorexia nervosa. Otherwise, evidence that avoidant-restrictive food intake disorder is associated with later diagnoses of other feeding and eating disorders is limited.

Developmental presentations

- Avoidant eating or feeding often starts in early childhood, but initial presentations in older children, adolescents and adults also occur.

Culture-related features

- Individuals who avoid specific foods because of widely accepted food choice practices, such as vegetarianism or veganism, or due to religious observances (e.g. fasting, purification or ritual proscription of foods), should not be diagnosed with the disorder unless the restricted eating behaviour exceeds the usual norms of the individual's cultural or religious group, and is associated with health or functional consequences that warrant clinical attention.

Sex- and/or gender-related features

- The prevalence of avoidant-restrictive food intake disorder is similar among males and females. When avoidant-restrictive food intake disorder co-occurs with autism spectrum disorder, prevalence is higher among males.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with anorexia nervosa

Individuals with anorexia nervosa, like individuals with avoidant-restrictive food intake disorder, present with a pattern of restricted eating and significantly low body weight, with similar health-related consequences. The difference is that in anorexia nervosa, behaviours to establish or maintain an abnormally low body weight are usually explicitly motivated by a desire for thinness or an intense fear of gaining weight. However, other rationales for disturbances in eating behaviours or weight loss in anorexia nervosa may be given, such as fear of physical discomfort (e.g. stomach bloating), self-punishment, or religious or moral reasons. In cases in which the individual otherwise meets the diagnostic requirements of anorexia nervosa but weight- or shape-related concerns are not explicitly endorsed, the altered eating behaviours should only be considered diagnostic of anorexia nervosa if clinical observation or collateral history supports the conclusion that they are motivated by an intention to lose weight or to prevent weight gain. Some individuals initially diagnosed with avoidant-restrictive food intake disorder may exhibit more explicit weight- or shape-related concerns over the course of treatment as they begin to alter their eating behaviours and to gain weight. In such cases, it may be appropriate to change the diagnosis to anorexia nervosa if all diagnostic requirements are met.

Boundary with autism spectrum disorder

In some individuals with avoidant-restrictive food intake disorder, the pattern of food avoidance stems from sensory sensitivities related to the smell, taste, temperature, texture or appearance of foods. For example, an individual may eat only foods of a particular colour, or will refuse solids or accept only a very narrow range of foods based on packaging or a particular brand. Some individuals with autism spectrum disorder may also restrict intake of certain foods because of their sensory characteristics (e.g. hypersensitivity to food texture) or because of inflexible adherence to particular routines (e.g. eating the same foods at the same time in the same order or only eating specific brands of food with specific packaging). However, autism spectrum disorder is also characterized by persistent deficits in initiating and sustaining social communication and reciprocal social interactions, and persistent restricted, repetitive and inflexible patterns of behaviour, interests or activities that are unrelated to food. If a pattern of restricted eating in an individual with autism spectrum disorder has caused significant weight loss or other health consequences or is specifically associated with significant functional impairment, an additional diagnosis of avoidant-restrictive food intake disorder may be assigned.

Boundary with specific phobia and other anxiety and fear-related disorders

In some individuals with avoidant-restrictive food intake disorder, food avoidance may be related to perceived aversive consequences of eating (e.g. fear that swallowing particular foods may cause one to gag, choke or vomit, or concern about the development of health problems such as heart disease or cancer related to food intake). Avoidant-restrictive food intake disorder is commonly associated with anxiety symptoms in situations related to eating or food, which may become worse over time as the disorder evolves. If the pattern and intensity of anxiety symptoms in an individual with avoidant-restrictive food intake disorder meet all diagnostic requirements of specific phobia or another anxiety or fear-related disorder, both diagnoses may be assigned.

Boundary with other mental disorders

Individuals experiencing a depressive episode may present with a lack of appetite or reduced interest in eating, and weight loss associated with depressed mood and other cognitive-behavioural or neurovegetative symptoms of a depressive episode. Similarly, individuals experiencing manic, mixed or hypomanic episodes may exhibit reduced interest in eating together with other features of a bipolar disorder. Avoidance or restriction of food intake with effects on weight and nutrition can also be present in schizophrenia and other primary psychotic disorders due to loss of appetite or due to paranoid ideas (e.g. fear of being poisoned). Motivations for restricted eating should be investigated carefully as a part of a complete mental health assessment in order to distinguish among these conditions. An additional diagnosis of avoidant-restrictive food intake disorder is generally not warranted if the restriction of food intake is fully accounted for by another mental disorder.

Boundary with other medical conditions

Avoidant-restrictive food intake disorder should not be diagnosed if the eating disturbance is entirely accounted for by a gastrointestinal disorder or another medical condition that leads to reduced hunger, restricted eating or weight loss (e.g. food allergies, infectious diseases, cancer, hyperthyroidism).

6B84 Pica

Essential (required) features

- Regular consumption of non-nutritive substances, such as non-food objects and materials (e.g. clay, soil, chalk, plaster, plastic, metal and paper), or raw food ingredients (e.g. large quantities of salt or corn flour) is required for diagnosis.
- The ingestion of non-nutritive substances is persistent or severe enough to require clinical attention. That is, the behaviour causes damage or significant risk to health or impairment in functioning due to the frequency, amount or nature of the substances or objects ingested.
- Based on age and level of intellectual functioning, the individual would be expected to distinguish between edible and non-edible substances. In typical development, this occurs at approximately 2 years of age.
- The symptoms or behaviours are not a manifestation of another medical condition (e.g. nutritional deficiency).

Boundary with normality (threshold)

- It is normal for infants and very young children to put non-food objects in their mouths as a means of sensory exploration. The diagnosis of pica should not be applied to this phenomenon.

- Many pregnant women crave or eat non-nutritive substances (e.g. chalk or ice). In addition, the eating of non-nutritive substances is a culturally sanctioned practice among certain groups. A diagnosis of pica should only be assigned to such behaviour if it is persistent or potentially dangerous enough to require specific clinical attention.

Course features

- Pica can be episodic and variable, or chronic and continuous. When variable, consumption of non-nutritive substances may be associated with increased levels of stress or anxiety.

Developmental presentations

- Onset of pica can occur across the lifespan, but is most commonly observed in childhood.

Culture-related features

- In some cases, eating of non-nutritive substances may be a culturally sanctioned practice. In these cases, consumption of the non-nutritive substance is thought to have some health, spiritual or social benefit. In parts of Africa and certain rural areas of the United States and India, for example, the eating of clay or earth (geophagia) can be a culturally accepted practice. Pica should not be diagnosed in such cases unless the quantities ingested are large enough to require clinical attention.

Sex- and/or gender-related features

- The prevalence of pica is similar among males and females.
- Although females can be diagnosed with pica during pregnancy and the postpartum period, a diagnosis should only be assigned if consumption of non-nutritive substances is persistent or potentially dangerous enough to require specific clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with nutritional deficiencies

Individuals who ingest non-nutritive substances as a symptom of specific nutritional deficiencies should not be diagnosed with pica unless the behaviour persists after the deficiency is corrected. For example, anaemia caused by vitamin B_{12}, folate or iron deficiency can be associated with a craving to eat dirt.

Boundary with disorders of intellectual development

The ingestion of non-nutritive substances is common in children or adults with disorders of intellectual development. An additional diagnosis of pica may be given, as long as that the individual is able to distinguish between edible and non-edible substances, if the behaviour is persistent or potentially dangerous enough to require specific clinical attention.

Boundary with factitious disorder and malingering

Individuals with factitious disorder or who are malingering may swallow harmful substances or objects in order to present themselves as ill. For example, prisoners may swallow harmful substances or objects in order to be transferred to hospital or to a setting that is less harsh or less restrictive. Pica should not be diagnosed in such cases.

Boundary with other mental, behavioural and neurodevelopmental disorders

Individuals with anorexia nervosa may eat non-nutritive substances (e.g. tissues, paper) in order to suppress hunger. In trichotillomania (hair-pulling disorder) or excoriation (skin-picking) disorder, individuals sometimes eat hair or skin that they pull or pick from the body. Eating of non-nutritive substances may also occur in other mental, behavioural or neurodevelopmental disorders such as autism spectrum disorder and schizophrenia. In all such cases, an additional diagnosis of pica should be assigned only if the behaviour is persistent or severe enough to require clinical attention. That is, the behaviour causes damage to health, impairment in functioning or significant risk due to the frequency, amount or nature of the substances or objects ingested.

6B85 Rumination-regurgitation disorder

Essential (required) features

- The intentional and repeated bringing up of previously swallowed food back to the mouth (regurgitation), which may be re-chewed and re-swallowed (rumination), or may be deliberately spat out (but not as in vomiting), is required for diagnosis.
- The regurgitation behaviour is frequent (at least several times per week) and sustained over a period of at least several weeks.
- The diagnosis should only be assigned to individuals who have reached a developmental age of at least 2 years.

- The regurgitation behaviour is not a manifestation of another medical condition that directly causes regurgitation (e.g. oesophageal strictures or neuromuscular disorders affecting oesophageal functioning) or causes nausea or vomiting (e.g. pyloric stenosis).

Additional clinical features

- In rumination-regurgitation disorder, the regurgitation behaviour is intentional; for example, individuals may contract the tongue or abdominal muscles or cough in order to induce regurgitation. Individuals with rumination-regurgitation disorder are able to regurgitate food with relative ease, and may derive some reduction of anxiety or pleasure from the behaviour.
- Individuals with rumination-regurgitation disorder often experience shame and embarrassment about the behaviour, and try to keep the behaviour a secret because they recognize it as socially unacceptable.
- Individuals with rumination-regurgitation disorder are often reluctant to seek treatment. The disorder may persist for a very long duration if left untreated.

Course features

- Rumination-regurgitation disorder is slightly more prevalent among individuals with disorders of intellectual development and autism spectrum disorder, whereby it may serve a self-soothing or self-stimulating function.
- Rumination-regurgitation disorder may be chronic or continuous, or it may be episodic. In episodic cases, the behaviour may be associated with stress or anxiety.
- Adolescents and adults may be less likely to re-chew the regurgitated food, and older adults may choose to swallow or spit out the material depending on the social situation.

Developmental presentations

- Onset of rumination-regurgitation disorder may occur across early and later childhood, adolescence and adulthood.
- Rumination-regurgitation disorder can create a substantial risk of choking in very young children due to their inability to control their swallowing.

Culture-related features

- Induced vomiting may be part of some yogic practices, and should not be considered a sign of the disorder unless the vomiting exceeds cultural norms and is associated with distress or impairment.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with infant rumination syndrome

Rumination-regurgitation disorder should not be diagnosed in infants. Similar phenomena in infants should be diagnosed as infant rumination syndrome in the grouping of functional digestive disorders of infants, toddlers or children in Chapter 13 on diseases of the digestive system.

Boundary with self-induced vomiting

Rumination-regurgitation disorder should be distinguished from self-induced vomiting. Self-induced vomiting may occur as a part of the presentation of anorexia nervosa, binge-purge pattern, or bulimia nervosa. Self-induced vomiting may also occur as a culturally sanctioned practice (e.g. among practitioners of yoga) that is not associated with a mental disorder.

Boundary with psychogenic vomiting

The differentiation from what has been considered to be "psychogenic vomiting", or vomiting as a somatoform expression of distress – particularly in South Asia – is based on the fact that regurgitation in rumination-regurgitation disorder is typically volitional and intentional. If there is evidence that "psychogenic vomiting" is voluntary, a diagnosis of rumination-regurgitation disorder may be appropriate.

6B8Y Other specified feeding and eating disorder

Essential (required) features

- The presentation is characterized by abnormal eating or feeding behaviours.
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the feeding and eating disorders grouping.

- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a primary psychotic disorder, a mood disorder or an obsessive-compulsive or related disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition that affects feeding or eating, are not better accounted for by another mental disorder, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms or behaviours result in significant risk or damage to health, significant distress, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6B8Z Feeding or eating disorder, unspecified

Elimination disorders

Elimination disorders include the repeated voiding of urine into bed or clothes (enuresis) and the repeated passage of faeces in inappropriate places (encopresis). These conditions occur in individuals at a developmental age when urinary and faecal continence is ordinarily expected to have been achieved, and may be voluntary or involuntary.

Elimination disorders include the following:

6C00 Enuresis

6C01 Encopresis

6C0Z Elimination disorder, unspecified.

6C00 Enuresis

Essential (required) features

- Repeated and persistent voiding of urine into bed or clothes (e.g. several times per week over several months), which may occur during the day or at night, is required for diagnosis.
- The individual has reached a developmental age when urinary continence is ordinarily expected (approximately equivalent to a chronological age of 5 years).
- The symptoms are not better accounted for by the physiological effects of a substance or medication, or by another medical condition that causes polyuria or urgency (e.g. a urinary tract infection, untreated diabetes mellitus, a neurogenic bladder, a disease of the nervous system, a disease of the musculoskeletal system or connective tissue, congenital or acquired abnormalities of the urinary tract).

Note: The symptom category MF50.2 Urinary incontinence or one of its subcategories from Chapter 21 on symptoms, signs or clinical findings, not elsewhere classified, may be considered when the presentation does not meet the diagnostic requirements for enuresis. The diagnosis for any underlying medical condition believed to be causing the urinary incontinence should also be assigned.

Specifiers for nocturnal or diurnal occurrence

6C00.0 Nocturnal enuresis

- Inappropriate voiding of urine occurs only during the night. This is the most common form of enuresis, and typically occurs during the first part of the night soon after the individual has gone to sleep.

6C00.1 Diurnal enuresis

- Inappropriate voiding of urine occurs only during waking hours. This form of enuresis is also referred to as "urinary incontinence".

6C00.2 Nocturnal and diurnal enuresis

- Inappropriate voiding of urine occurs both during the night and during waking hours.

6C00.Z Enuresis, unspecified

Additional clinical features

- Voiding of urine is typically involuntary but, in some cases, may appear to be voluntary. The diagnosis can be assigned in either case.
- Voiding of urine during sleep may take place during rapid eye movement (REM) sleep, leading some individuals to report having dreamt of urinating.
- Diurnal enuresis may occur in children who avoid urination due to social anxiety about using a public bathroom or due to refusal to cease an activity that is enjoyable (e.g. playing a game).
- Enuresis may lead to the development of psychological problems due to associated distress or stigma. Enuresis may be an aspect of another mental, behavioural or neurodevelopmental disorder, or both enuresis and another emotional/behavioural disturbance may arise in parallel due to related etiological factors. A diagnosis of enuresis may be assigned together with other mental, behavioural or neurodevelopmental disorder diagnoses if the enuresis is a distinct focus of clinical attention.

- Enuresis is common among individuals with disorders of intellectual development. The diagnosis should only be assigned if all diagnostic requirements of enuresis are met, and the individual's developmental age is equivalent to that at which urinary continence in normally expected (approximately equivalent to a chronological age of 5 years).
- Enuresis can occur among individuals with neurocognitive disorders (e.g. dementia). The additional diagnosis of enuresis can be assigned if all diagnostic requirements are met, and the condition requires separate clinical attention.
- Enuresis is more common among children with a parent who has a history of enuresis.

Boundary with normality (threshold)

- It is not uncommon for children to experience occasional urinary incontinence up until middle childhood.

Course features

- Most children establish urinary control by adolescence, with a small number of individuals continuing to experience enuresis into adulthood.
- Enuresis that persists into adolescence is often associated with an increase in frequency of urinary voiding episodes.

Developmental presentations

- Enuresis may have been present from birth (i.e. an atypical extension of normal infantile incontinence), or may have its onset following a period of acquired bladder control.
- The common age of onset for children who have previously acquired urinary continence yet develop enuresis is between 5 and 8 years.
- Diurnal enuresis is less prevalent among children over the age of 9 years.

Culture-related features

- Cultural variation exists with regard to toilet training. Expectations regarding the age when continence occurs and whether enuresis is viewed as pathological vary by cultural group. Cultural norms may affect tolerance for the behaviours, expectations regarding their course, and the associated level of shame and stigma.

Sex- and/or gender-related features

- Nocturnal enuresis is more prevalent among males, whereas diurnal enuresis is more prevalent among females.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with the effects of substances including medications

Enuresis may occur due to certain antipsychotic medications, diuretics or other substances or medications that stimulate incontinence. In these cases, incontinence should be considered a side-effect, and a diagnosis of enuresis is typically not warranted. If the enuresis was present before administration of medication, it may be appropriate to assign a diagnosis.

Boundary with other medical conditions

Enuresis should not be diagnosed if the symptoms are better accounted for by another medical condition that causes polyuria or urgency. A diagnosis of enuresis may be warranted if the urinary incontinence was present before the other medical condition developed, or persists after the individual has received treatment.

6C01 Encopresis

Essential (required) features

- Repeated and persistent passage of faeces in inappropriate places (e.g. at least once per month over a period of several months) is required for diagnosis.
- The individual has reached the developmental age when faecal continence is ordinarily expected (approximately equivalent to a chronological age of 4 years).
- Faecal soiling is not better accounted for by the physiological effects of a substance (e.g. excessive use of laxatives) or another medical condition (e.g. aganglionic megacolon, spina bifida, anal stenosis, chronic diarrhoea, congenital or acquired abnormalities of the bowel or gastrointestinal infection).

Note: The symptom category ME07 Faecal incontinence or one of its subcategories from Chapter 21 on symptoms, signs or clinical findings, not elsewhere classified, may be considered when the presentation does not meet the diagnostic requirements for encopresis. The diagnosis for any underlying medical condition believed to be causing the faecal incontinence should also be assigned.

Specifiers for the presence of constipation and overflow

6C01.0 Encopresis with constipation and overflow incontinence

- Encopresis with constipation and overflow incontinence is the most common form of faecal soiling, and is characterized by retention and impaction of faeces. Stools are typically – but not always – poorly formed (loose or liquid), and leakage may range from occasional to continuous.
- There is often a history of toilet avoidance leading to constipation.

6C01.1 Encopresis without constipation and overflow incontinence

- Encopresis without constipation and overflow incontinence is not associated with retention and impaction of faeces but rather is characterized by reluctance, resistance or failure to conform to social norms in defecating in acceptable places in the context of normal physiological control over defecation.
- Stools are typically of normal consistency, and inappropriate defecation is likely to be intermittent.

6C01.Z Encopresis, unspecified

Additional clinical features

- Encopresis is most often involuntary but, in some cases, may appear to be voluntary. The diagnosis can be assigned in either case. Involuntary passage of faeces is most often associated with encopresis with constipation and overflow incontinence.
- Encopresis that is intentional may be associated with oppositional defiant disorder or conduct-dissocial disorder.
- Stool withholding, or retentive behaviours, may be the result of avoidance of bowel movements, especially in those individuals with a history of difficulty or pain in passing stools. Individuals with chronic constipation and stool retention may go on to develop acquired megacolon.
- Specific phobias or social anxiety disorder (e.g. fear of using public bathrooms) may also contribute to retentive behaviours.
- Encopresis is common among individuals with disorders of intellectual development. The diagnosis should only be assigned if all diagnostic requirements are met, and the individual's developmental age is equivalent to that at which faecal continence in normally expected (approximately equivalent to a chronological age of 4 years).

- Encopresis can occur among individuals with neurocognitive disorders (e.g. dementia). The additional diagnosis of encopresis can be assigned if all diagnostic requirements are met, and the condition requires separate clinical attention.
- Individuals diagnosed with encopresis may experience embarrassment and reduced self-esteem. Older children diagnosed with encopresis may experience impairments in social functioning due to peer teasing and possible social isolation. Furthermore, individuals with encopresis may avoid social situations for fear of passing faeces in the presence of other people.
- Individuals with encopresis and chronic constipation may also experience co-occurring symptoms of enuresis. Both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with normality (threshold)

- It is not uncommon for children to experience an occasional soiling accident during early childhood. Faecal incontinence must occur frequently and persistently to warrant a diagnosis.

Course features

- Encopresis can persist for years, with recurrent episodes of worsening symptoms.

Developmental presentations

- Faecal incontinence may have been present from birth (i.e. an atypical extension of normal infantile incontinence), or may have its onset following a period of acquired bowel control.
- Encopresis has a high prevalence (between 1.5% and 7.5%) among school-aged children between the ages of 6 and 12 years.

Sex- and/or gender-related features

- Encopresis is more prevalent among males.
- Females may be more likely to experience urinary tract infections co-occurring with encopresis due to contamination of the urethra with faecal bacteria.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with the effects of substances including medications

Faecal incontinence may occur due to certain medications including some antibiotics, some cancer medications, laxatives and antacids that contain magnesium. In these cases, a diagnosis of encopresis is typically not warranted. If the encopresis was present before administration of medication, it may be appropriate to assign a diagnosis.

Boundary with other medical conditions

Encopresis should not be diagnosed if the symptoms are better accounted for by another medical condition that causes faecal incontinence. A diagnosis of encopresis may be warranted if the faecal incontinence was present before the other medical condition developed, or persists after the individual has received adequate treatment.

6C0Z Elimination disorder, unspecified

Disorders of bodily distress or bodily experience

Disorders of bodily distress or bodily experience are characterized by disturbances in the person's experience of their body. Bodily distress disorder involves bodily symptoms that the individual finds distressing, and to which excessive attention is directed. Body integrity dysphoria involves a disturbance in the person's experience of the body manifested in the persistent desire to have a specific physical disability, accompanied by persistent discomfort or intense feelings of inappropriateness concerning current non-disabled body configuration.

Disorders of bodily distress or bodily experience include the following:

- **6C20** Bodily distress disorder
- **6C21** Body integrity dysphoria
- **6C2Y** Other specified disorder of bodily distress or bodily experience
- **6C2Z** Disorder of bodily distress or bodily experience, unspecified.

6C20 Bodily distress disorder

Essential (required) features

- The presence of bodily symptoms that are distressing to the individual is required for diagnosis. Typically, this involves multiple bodily symptoms that may vary over time. Occasionally, the focus is limited to a single symptom – usually pain or fatigue.

- Excessive attention is directed towards the symptoms, which may manifest in:
  - persistent preoccupation with the severity of the symptoms or their negative consequences – in individuals who have an established medical condition that may be causing or contributing to the symptoms, a degree of attention related to the symptoms that is clearly excessive in relation to the nature and severity of the medical condition;
  - repeated contacts with health-care providers related to the bodily symptoms that are substantially in excess of what would be considered medically necessary.
- Excessive attention to the bodily symptoms persists, despite appropriate clinical examination and investigations or appropriate reassurance from health-care providers.
- Bodily symptoms are persistent; that is, some symptoms are present (although not necessarily the same symptoms) on most days during a period of at least several months (e.g. 3 months or more).
- The bodily symptoms and related distress and preoccupation result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- The symptoms or the associated distress and preoccupation are not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, or an anxiety or fear-related disorder).

Severity of bodily distress disorder

The severity of bodily distress disorder should be classified based on the degree of distress or preoccupation with bodily symptoms, the persistence of the disorder and the degree of impairment. The clinician should make a global determination of the appropriate rating of severity based on the overall clinical presentation, and select one of the following subcategories.

6C20.0 Mild bodily distress disorder

- All the essential features of bodily distress disorder are present.
- Although there is excessive attention to distressing symptoms and their consequences, which may result in frequent medical visits, the individual spends only a limited amount of time focusing on them (e.g. no more than 1 or 2 hours per day), and is able to focus on other unrelated topics.
- The bodily symptoms and related distress and preoccupation result in mild impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. strain in relationships, less effective academic or occupational functioning, abandonment of specific leisure activities).

6C20.1 Moderate bodily distress disorder

- All the essential features of bodily distress disorder are present.
- Persistent preoccupation with the distressing symptoms and their consequences is typically

associated with frequent medical visits. The individual devotes a substantial amount of time and energy to focusing on the symptoms and their consequences (e.g. several hours per day).

- The bodily symptoms and related distress and preoccupation result in moderate impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. relationship conflict, performance problems at work, abandonment of a range of social and leisure activities).

6C20.2 Severe bodily distress disorder

- All the essential features of bodily distress disorder are present.
- The presentation is characterized by a pervasive and persistent preoccupation with the distressing symptoms and their consequences, and a narrowing of interests such that the bodily symptoms and their consequences become the nearly exclusive focus of the individual's life, typically resulting in extensive interactions with the health-care system.
- The bodily symptoms and related distress and preoccupation result in severe impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. unable to work, alienation of friends and family, abandonment of nearly all social and leisure activities).

6C20.Z Bodily distress disorder, unspecified

Additional clinical features

- The most common bodily symptoms associated with bodily distress disorder include pain (e.g. musculoskeletal pain, backache, headaches), fatigue, and gastrointestinal and respiratory symptoms, although patients may be preoccupied with any bodily symptoms. The individual can generally provide a detailed description of the symptoms, but it may be difficult for clinicians to account for the symptoms in anatomical or physiological terms.
- Individuals with bodily distress disorder often over-interpret or catastrophize about their bodily symptoms, and dwell on their most extreme negative consequences. For example, in more severe cases, pain or fatigue may be perceived as being so intense that they prevent normal activities, despite there being no medical basis for such a belief. This is often accompanied by fear of triggering pain or an exacerbation of other symptoms, which may lead to undue avoidance of activities; this may in turn lead to other symptoms associated with inactivity (e.g. stiffness and muscle weakness, muscle pain following minimal exertion).
- Individuals with bodily distress disorder may hold a range of attributions regarding their symptoms, including psychological and physical explanations. As severity increases, affected individuals are more likely to reject psychological explanations for their symptoms. Some individuals with bodily distress disorder believe that their bodily symptoms indicate underlying physical illness or injury (i.e. disease conviction), even though this has not been detected. Insistence that the symptoms are caused by an undiagnosed illness or

injury may result in multiple medical tests and procedures. This pattern is most common in individuals with severe bodily distress disorder, who may have long and complicated histories of contact with both primary and specialist medical services, during which many negative investigations or fruitless operations across various body systems may have been carried out.

- Individuals with bodily distress disorder most often present in general medical settings rather than for mental health services. They may be reluctant to agree that there is a psychological component to their experience, and may react negatively to the suggestion of a referral to a mental health professional.
- Individuals with bodily distress disorder often express dissatisfaction with the medical care they have received previously, and may change health-care providers frequently.
- In communities with limited access to health care, individuals with bodily distress disorder may not have extensive interactions with the formal health-care system, but they may seek care from alternative sources.
- Bodily distress disorder often occurs in the context of comorbid medical conditions and co-occurring mental disorders – especially depressive disorders and anxiety and fear-related disorders.

Boundary with normality (threshold)

- The experience of bodily symptoms and occasional concern about them is normal. However, people with bodily distress disorder report greater distress about their bodily symptoms than would generally be regarded as proportional to the nature of the symptoms, and their excessive attention to their symptoms is not alleviated by appropriate clinical examination and investigations, and by reassurance from health-care providers.
- Individuals with bodily distress disorder who have a comorbid medical condition that may be causing or contributing to the bodily symptoms exhibit greater preoccupation with symptoms and greater functional impairment than those who have a medical condition that is similar in nature and severity without concurrent bodily distress disorder. Furthermore, the number of bodily symptoms reported often exceeds that usually associated with the comorbid medical condition.

Course features

- In about half of individuals diagnosed with bodily distress disorder seen in primary care settings, bodily symptoms resolve within 6–12 months. Individuals with severe disorder and those with multiple bodily symptoms tend to experience a more chronic and persistent course. The presence of multiple bodily symptoms is commonly associated with greater impairment in functioning, as well as with poorer treatment response for any co-occurring mental or medical conditions.

Developmental presentations

- Bodily distress disorder can occur across the lifespan. The most common bodily symptoms in children and adolescents include recurrent gastrointestinal symptoms (e.g. abdominal pain, nausea), fatigue, headaches and musculoskeletal pain. Children are more likely to experience a single recurrent symptom rather than multiple bodily symptoms. School absences due to symptoms are common. In severe cases, children may display regression of behaviour and extreme impairment – for example, affecting self-care and mobility.
- In children and adolescents, parental or caregiver responses to symptoms can affect the course and severity of bodily distress disorder, as well as whether medical attention is sought. For example, excessive parental or caregiver concern can worsen the severity or prolong the course of the disorder in children.
- Older adults with bodily distress disorder are more likely than younger adults with the condition to have multiple bodily symptoms, and symptoms are more likely to be persistent. The diagnosis of bodily distress disorder in older adults can be challenging due to the higher likelihood of medical conditions that may account for symptoms, or that are comorbid with bodily distress disorder.

Culture-related features

- Somatic symptoms are common in all cultural groups, especially among people seeking health care. Differences in rates of bodily symptoms may be related to cultural reporting styles. Differences may also reflect the organizational culture of the health-care system, with somatic complaints more likely where clinical encounters are brief and the delivery of services is less person-centred.
- Symptoms that are common in one cultural group may be less common in other groups. For example, whereas pain symptoms are common across cultures, symptoms such as heat in the body or in the head, crawling sensations, heaviness, or complaints of "gas" or abdominal bloating are common in certain cultural group but not in others.
- Culture may influence explanatory models, with symptoms variously attributed to forms of bodily energy, humours or other ethno-physiological concepts, as well as religious, spiritual, personal, family or environmental stresses. Some specific attributions, such as symptoms being caused by semen loss or kidney weakness, are common in certain cultural group but not in others.
- Across cultural groups, people with multiple distressing bodily symptoms are likely to seek health care, including from traditional or faith healers. However, help-seeking behaviour is also substantially influenced by access to health-care services. Individuals may not have extensive interactions with the formal health-care system because of limited opportunities to access health care, which varies substantially by cultural group.

Sex- and/or gender-related features

- Prevalence rates do not appear to differ by gender prior to puberty, after which prevalence is higher in females.
- Symptom presentation may vary by gender, with women more likely to report multiple bodily concerns.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with mood disorders

Among individuals with mood disorders, somatic symptoms may be the dominant aspects of the clinical presentation – particularly in primary care settings. In addition, some individuals with mood disorders may develop neurovegetative symptoms (e.g. weight loss, fatigue) or other associated physical symptoms (e.g. pain), about which they become preoccupied. Bodily distress disorder should be diagnosed only if the preoccupation with physical symptoms occurs outside the context of mood episodes – for example, if the preoccupation precedes a depressive episode or persists after the depressive episode has remitted.

Boundary with generalized anxiety disorder

Individuals with generalized anxiety disorder may report somatic symptoms about which they are concerned (e.g. palpitations or gastric distress), but they also report concerns about negative events occurring in several different aspects of everyday life (e.g. work, relationships, finance). Unlike individuals with bodily distress disorder, individuals with generalized anxiety disorder do not typically exhibit a preoccupation with bodily symptoms that persists despite medical evaluation and reassurance. However, co-occurrence of bodily distress disorder and anxiety and fear-related disorders is common, although individuals with bodily distress disorder are less likely to endorse the psychological components of anxiety other than distress about their bothersome symptoms.

Boundary with panic disorder

Panic disorder is characterized by recurrent, unexpected, self-limited episodes of intense fear or apprehension with prominent somatic symptoms and feelings of an impending catastrophe (e.g. fainting, having a stroke, heart attack or dying), with a sense of immediacy of the threat. Individuals with panic disorder often become preoccupied with the transient somatic symptoms they experience during panic attacks, and may express concern that they are dangerous and suggestive of imminent harm. An additional diagnosis of bodily distress disorder should not be assigned on the basis of concern about symptoms experienced during panic attacks. However, if individuals with panic disorder are excessively attentive to or preoccupied by persistent somatic symptoms that are distinct from those typically associated with panic attacks, and all diagnostic requirements for both disorders are met, both diagnoses may be assigned.

Boundary with hypochondriasis (health anxiety disorder)

Unlike individuals with hypochondriasis, who are preoccupied with the possibility of having one or more serious, progressive or life-threatening illnesses, individuals with bodily distress disorder are typically preoccupied by the symptoms themselves and the impact of the symptoms on their lives. Individuals with hypochondriasis may also seek medical attention, but their primary purpose is to obtain reassurance that they do not have the feared serious medical condition. Individuals with bodily distress disorder typically seek medical attention in order to get relief from their symptoms, not to disconfirm the belief that they have a serious medical illness.

Boundary with factitious disorder imposed on self

Individuals with factitious disorder imposed on self may also present bodily symptoms. If the presented symptoms have been feigned, falsified or intentionally induced or aggravated, factitious disorder imposed on self rather than bodily distress disorder is the appropriate diagnosis.

6C21 Body integrity dysphoria

Essential (required) features

- An intense and persistent desire to become physically disabled in a significant way (e.g. a major limb amputation, paraplegia, blindness) accompanied by persistent discomfort or intense negative feelings about one's current body configuration or functioning, is required for diagnosis.
- The desire to be disabled results in harmful consequences, manifested in either or both of the following:
  - attempts to actually become disabled through self-injury, which have resulted in the person putting their health or life in significant jeopardy;
  - preoccupation with the desire to be disabled, resulting in significant impairment in personal, family, social, educational, occupational or other important areas of functioning (e.g. avoidance of close relationships, interference with work productivity).
- Onset of the persistent desire to be disabled occurs by early adolescence.
- The disturbance is not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder – in which, for example, a delusional conviction that the limb belongs to another person may be present – or factitious disorder) or by malingering.
- The symptoms or behaviours are not better accounted for by gender incongruence, by a disease of the nervous system or by another medical condition.

Additional clinical features

- It is common for individuals to describe their discomfort in terms of feeling like they should have been born with the desired disability (e.g. missing a leg).
- Most individuals with this condition exhibit associated "pretending" or simulation behaviour (e.g. binding one's leg to simulate being a person with a limb amputation, or using a wheelchair or crutches), which is often the first manifestation of the condition. These behaviours are usually done in secret. The need for secrecy may result in avoidance or termination of intimate relationships that would interfere with opportunities for simulation.
- Some individuals who attempt to make themselves disabled through self-injury try to cover up the self-inflicted nature of the attempt by making it look like an accident.
- Many individuals with body integrity dysphoria have a sexual component to their desire – either being sexually attracted to individuals with certain disabilities or being intensely sexually aroused at the thought of being disabled.
- Shame about the desire to be disabled is common in individuals with body integrity dysphoria, and most individuals keep this desire a closely guarded secret because of a fear of being rejected or thought to be "crazy" by others. It is common for the family, friends, co-workers and even their partners or spouses of individuals with body integrity dysphoria to be unaware of their desire. Some may seek treatment for associated depressive or other symptoms and yet not share their desire to be disabled with their health-care provider.
- It is assumed that most individuals with body integrity dysphoria never come to clinical attention. When they do, it is generally as adults – often when they seek the assistance of a health-care professional to relieve their distress, to help them actualize their desired disability, or because they have injured themselves in an attempt to become disabled.

Boundary with normality (threshold)

- Some individuals, especially children and adolescents, may have time-limited periods in which they pretend to have a disability such as blindness out of curiosity about what it is like to live as a disabled person. Such individuals do not experience a persistent desire to become disabled or the harmful consequences associated with body integrity dysphoria.

Course features

- The typical course is for the intensity of the desire to become disabled and consequent functional impairment to wax and wane. There may be periods of time where the intensity of the desire and the accompanying dysphoria is so great that the individual can think of

nothing else, and may make plans or take action to become disabled. At other times, the desire to become disabled and the associated intense negative feelings abate, although at no time does it completely cease to be present.

Developmental presentations

- The onset of body integrity dysphoria is most commonly in early to mid-childhood, although some cases have their onset in adolescence. The first manifestation is typically the child pretending to have the desired disability, often in secret.

Culture-related features

- Although apparently quite rare, cases have been reported in many different countries and cultures.

Sex- and/or gender-related features

- Among those who come to clinical attention, prevalence appears to be higher among males.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia, other primary psychotic disorders, and other mental disorders with psychotic symptoms

Somatic delusions may involve the conviction that a part of the person's body does not belong to them. In such cases, a diagnosis of schizophrenia or another primary psychotic disorder, or a mood disorder with psychotic symptoms should be considered. Individuals with body integrity dysphoria do not harbour false beliefs about external reality related to their desire to be disabled, and thus are not considered to be delusional. Instead, they experience an internal feeling that they would be "right" only if they were disabled.

Boundary with obsessive-compulsive disorder

Obsessive-compulsive disorder is characterized by repetitive and persistent thoughts, images or urges that are experienced as intrusive and unwanted (ego-dystonic). In contrast, the repetitive

thoughts, images and impulses related to the desire to become disabled in body integrity dysphoria (e.g. fantasies of being disabled) are ego-syntonic, and are not experienced as intrusive, unwanted or distressing. Distress in body integrity dysphoria is typically related to not being able to actualize the disability, or to fear of the negative judgements of others.

Boundary with body dysmorphic disorder

Individuals with body dysmorphic disorder have persistent preoccupations about a part of their body that they believe is defective, or a perception that their appearance overall is ugly. In contrast, individuals with body integrity dysphoria are persistently preoccupied with a sense that the way their body is configured (e.g. for those who desire an amputation) or functions (e.g. for those who want to be paraplegic or blind) is wrong, unnatural and not as it should be.

Boundary with paraphilic disorder involving solitary behaviour or consenting individual

Some individuals have a paraphilic focus of intense sexual arousal involving the fantasy of having a serious disability, which may be associated with transient periods of wanting to acquire the disability that is the source of arousal. If the desire to acquire a disability occurs solely in connection with sexual arousal, body integrity dysphoria should not be diagnosed. A diagnosis of paraphilic disorder involved solitary behaviour or consenting individuals may be appropriate in such cases, if the individual is markedly distressed about this arousal pattern or if they have injured themselves as a part of enacting sexual fantasies related to it.

Boundary with factitious disorder and malingering

Individuals with body integrity disorder often simulate their desired disability as a way of reducing their negative feelings (e.g. a person who desires to be paraplegic may spend part or all of their time using a wheelchair). Moreover, they typically shun medical attention. In contrast, individuals with factitious disorder feign medical or psychological signs or symptoms in order to seek attention – especially from health-care providers – and to assume the sick role. Malingering is characterized by feigning of medical or psychological signs or symptoms for obvious external incentives (e.g. disability payments).

Boundary with diseases of the nervous system

Some diseases of the nervous system may cause symptoms that involve profound changes in the person's attitude towards and experience of their own bodies (e.g. somatoparaphrenia, in which a paralysed body part is experienced as alien or as belonging to someone else.) If the persistent discomfort about the individual's body configuration is better accounted for by a disease of the nervous system, then body integrity dysphoria should not be diagnosed.

6C2Y Other specified disorder of bodily distress or bodily experience

Essential (required) features

- The presentation is characterized by disturbances in the person's experience of their body that share primary clinical features with other disorders of bodily distress or bodily experience (e.g. distressing bodily symptoms to which excessive attention is directed, or intense feelings of inappropriateness concerning one's body configuration or functioning).
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the disorders of bodily distress or bodily experience grouping.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. a mood disorder, schizophrenia or another primary psychotic disorder, an eating disorder).
- The symptoms have persisted for at least several months.
- The symptoms or behaviours are not developmentally appropriate (e.g. focused on bodily changes during puberty) or culturally sanctioned.
- The symptoms or behaviours are not accounted for by gender incongruence or by another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6C2Z Disorder of bodily distress or bodily experience, unspecified

Disorders due to substance use or addictive behaviours

Disorders due to substance use

Disorders due to substance use include disorders that result from a single occasion or repeated use of substances that have psychoactive properties, including certain medications. Disorders related to 14 classes or groups of psychoactive substances that have important clinical and public health consequences are included, and categories are also available for other specified substances.

Typically, initial use of these substances produces pleasant or appealing psychoactive effects that are rewarding, and this response is reinforced with repeated use. With continued use, many of the substances included here have the capacity to produce dependence. They also have the potential to cause numerous forms of harm – to both mental and physical health. Disorders due to harmful nonmedical use of non-psychoactive substances (e.g. laxatives, growth hormone, erythropoietin and non-steroidal anti-inflammatory drugs) are also included in this grouping.

General cultural considerations for disorders due to substance use

- Use of psychoactive substances is influenced by strong cultural meanings and traditions, which may affect the risk of development of a disorder due to substance use. The cultural milieu in which the substance is used should be considered when determining risk and the presence or absence of pathology. For example, substances may be used regularly as part of religious rituals, celebrations (e.g. New Year's Eve), culturally sanctioned mystical experiences, specific events (e.g. wakes preceding funerals) or healing activities without resulting in a disorder due to substance use.
- Cultural values and interpretations related to the use of psychoactive substances in specific communities, and cultural terms used to describe the substance and its effects, vary greatly across cultures. Knowledge of specific terms and interpretations will improve communication with patients and determination of possible disorder. For example, American Indians who use peyote during traditional worship ceremonies may consider the substance a sacrament rather than a drug.

- Local availability of a substance affects the prevalence of disorders associated with it. For example, prevalence of alcohol dependence is lower in predominantly Muslim countries due to the religious prohibitions against alcohol consumption.
- Immigration may affect an individual's pattern of substance as a result of changes in culture, including gender roles. Such changes can lead to higher or lower risk of disorders due to substance use depending on the characteristics of the sending and receiving societies, the circumstances of migration, and the relative social position in each setting. For example, immigrants moving from a society with high alcohol consumption to one with low alcohol consumption tend to assume the lower risk of disorder of the host country.

Substance classes

Disorders due to substance use are classified by first identifying the substance used. Available substance classes included are listed below, with a brief description of their properties, typical preparations and methods of use, as well as associated harms and disorders.

6C40 Disorders due to use of alcohol

Disorders due to use of alcohol are characterized by the pattern and consequences of alcohol use. Alcohol – more specifically termed ethyl alcohol or ethanol – is an intoxicating compound produced by fermentation of sugars, usually in agricultural products such as fruits, cereals and vegetables, with or without subsequent distillation. There are a wide variety of alcoholic drinks, with alcohol concentrations typically ranging from 1.5% to 60%. Alcohol is predominantly a central nervous system depressant. Unlike most other substances, elimination of alcohol from the body occurs at a constant rate, such that its clearance follows a linear rather than a logarithmic course. In addition to ability to produce alcohol intoxication, alcohol has dependence-producing properties, resulting in alcohol dependence in some people and alcohol withdrawal when alcohol use is reduced or discontinued.

Alcohol is implicated in a wide range of harms affecting most organs and systems of the body (e.g. cirrhosis of the liver, gastrointestinal cancers, pancreatitis). Harm to others resulting from behaviour during alcohol intoxication is well recognized, and is included in the definitions of categories of harmful use of alcohol (i.e. episode of harmful use of alcohol and harmful pattern of use of alcohol). Several alcohol-induced mental disorders (e.g. alcohol-induced psychotic disorder) and alcohol-related forms of neurocognitive impairment (e.g. dementia due to use of alcohol) are also recognized.

Alcohol use is one of the most common causes of premature death and illness among men, and is still a substantial – though less common – cause of premature death and illness among women. The use of alcohol is implicated in millions of deaths per year (e.g. due to motor vehicle accidents).

Although alcohol is used worldwide, and its use is legal among adults in most countries, there are substantial differences in cultural and religious acceptability of its use. Consequently, prevalence

of alcohol use disorders shows substantial regional variation; the highest prevalence is observed in eastern Europe and the lowest in Africa. Low prevalence of alcohol use in some countries is related to lower rates of disorders due to use of alcohol.

Polymorphisms of the genes for the alcohol-metabolizing enzymes alcohol dehydrogenase (ADH1B) and aldehyde dehydrogenase, which affect the response to alcohol, are seen more frequently among East Asians than other groups. Individuals with certain polymorphisms may develop facial flushing and palpitations when consuming alcohol, which may be so severe as to preclude alcohol consumption and thus lower the risk of alcohol use disorder.

6C41 Disorders due to use of cannabis

Disorders due to use of cannabis are characterized by the pattern and consequences of cannabis use. Cannabis is the collective term for a range of psychoactive preparations of the cannabis plant, *Cannabis sativa*, and related species and hybrids. Cannabis contains cannabinoids, a class of diverse chemical compounds that act on endogenous cannabinoid receptors that modulate neurotransmitter release in the brain. The principal psychoactive cannabinoid is δ-9-tetrahydrocannabinol (THC). Cannabis is typically smoked in the form of the flowering heads or leaves of the marijuana plant; tobacco is often mixed with cannabis when smoked. Cannabis oils are also prepared from these same sources. These preparations vary considerably in their THC potency. Cannabis has predominantly central nervous system depressant effects; it produces a characteristic euphoria that may be part of the presenting features of cannabis intoxication, which may also include impairment in cognitive and psychomotor functioning. Cannabis has dependence-producing properties resulting in cannabis dependence in some people and cannabis withdrawal when use is reduced or discontinued. Cannabis is associated with a range of cannabis-induced mental disorders. Other medical conditions are also associated with cannabis use, including some respiratory and cardiovascular diseases.

Cannabis is the most commonly used illicit drug worldwide, but its legal status varies considerably; in certain countries it is legally available for medicinal or personal use. Acceptance of cannabis use for recreational or medical purposes also varies widely by culture. Variations in legal status and cultural acceptability are related to differential consequences for detection of use (e.g. arrest, school suspension or employment suspension), affecting the probability that the person may seek treatment.

6C42 Disorders due to use of synthetic cannabinoids

Disorders due to use of synthetic cannabinoids are characterized by the pattern and consequences of synthetic cannabinoid use. Synthetic cannabinoids are synthesized diverse chemical compounds that are potent agonists for endogenous cannabinoid receptors. There are several hundred such compounds. The synthetic compound is typically sprayed onto a vehicle such as cannabis or tea leaves and then smoked. The effect of these compounds is distinctly different from smoking naturally cultivated cannabis, in that the euphoric effects are typically accompanied or dominated by psychotic-like symptoms (e.g. paranoia, hallucinations and disorganized

behaviour). Synthetic cannabinoid intoxication may therefore present more frequently with psychotic symptoms in addition to the more typical effects of cannabis. Synthetic cannabinoids also have dependence-producing properties, and synthetic cannabinoid dependence and synthetic cannabinoid withdrawal are recognized. Synthetic cannabinoid-induced mental disorders also occur; in particular, synthetic cannabinoid-induced psychotic disorder is recognized. Much less is known about the effects of these drugs on other body organs and systems than is the case for naturally cultivated cannabis.

6C43 Disorders due to use of opioids

Disorders due to use of opioids are characterized by the pattern and consequences of opioid use. "Opioids" is a generic term that encompasses the constituents or derivatives of the opium poppy, *Papaver somniferum*, as well as a range of synthetic and semisynthetic compounds – some related to morphine and others chemically distinct, but all having their primary actions on the μ opioid receptor. Examples of opioids include morphine, diacetylmorphine (heroin), fentanyl, pethidine, oxycodone, hydromorphone, methadone, buprenorphine, codeine and d-propoxyphene. The opioids all have analgesic properties of different potencies, and are primarily central nervous system depressants. They suppress respiration and other vital functions, and are a common cause of overdose and related deaths. Certain opioids are used or administered parenterally, including heroin – a common and potent opioid that is primarily used nonmedically. Therapeutic opioids are prescribed for a range of indications worldwide, and are essential for pain management in cancer care and palliative care, although they are also used for nontherapeutic reasons. In some countries, morbidity and mortality related to therapeutic opioids are greater than those related to heroin. All opioids may result in opioid intoxication, opioid dependence and opioid withdrawal. A range of opioid-induced disorders occur, some of which occur following opioid withdrawal. Because certain opioids are commonly injected illicitly, their use is a potent mechanism of transmission of bloodborne viral infections such as hepatitis B, hepatitis C and HIV/AIDS, as well as bacterial infections. Not including alcohol and tobacco, opioids are the most common cause of death from psychoactive drug use worldwide.

6C44 Disorders due to use of sedatives, hypnotics or anxiolytics

Disorders due to use of sedatives, hypnotics or anxiolytics are characterized by the pattern and consequences of use of these substances. Sedatives, hypnotics and anxiolytics are typically prescribed for the short-term treatment of anxiety or insomnia, and are also employed to provide sedation for medical procedures. They include benzodiazepines and the non-benzodiazepine positive allosteric modulators of GABA receptors (i.e. "Z-drugs"), as well as many other compounds. Sedatives, hypnotics and anxiolytics include barbiturates, which are available much less commonly now than in previous decades. Sedatives, hypnotics and anxiolytics have dependence-inducing properties that are related to the dose and duration of their use. They may cause intoxication, dependence and withdrawal. Several other mental disorders induced by sedatives, hypnotics or anxiolytics are recognized.

6C45 Disorders due to use of cocaine

Disorders due to use of cocaine are characterized by the pattern and consequences of cocaine use. Cocaine is a compound found in the leaves of the coca plant, *Erythroxylum coca*, which is indigenous to countries in northern regions of South America. Cocaine has a limited place in medical treatment as an anaesthetic and vasoconstrictive agent. It is commonly used illicitly, and is widely available across the world, where it is found in two main forms: cocaine hydrochloride and cocaine freebase (also known as "crack"). Cocaine is a central nervous system stimulant, and cocaine intoxication typically includes a state of euphoria and hyperactivity. Cocaine has potent dependence-producing properties, and cocaine dependence is a common cause of morbidity and of clinical presentations. Cocaine withdrawal has a characteristic course that includes lethargy and depressed mood. A range of cocaine-induced mental disorders is described. Cocaine is also associated with several health sequelae, including myocardial infarction arising from coronary artery spasm and stroke arising from cerebral artery spasm.

6C46 Disorders due to use of stimulants, including amfetamines, methamfetamine and methcathinone

Disorders due to use of stimulants, including amfetamines, methamfetamine and methcathinone, are characterized by the pattern and consequences of use of these substances. There is a wide array of naturally occurring and synthetically produced psychostimulants other than cocaine. The most numerous of this group are the amfetamine-type substances, including methamfetamine. Prescribed stimulants including dexamfetamine are indicated for a limited number of conditions, such as for attention deficit hyperactivity disorder. Methcathinone, known in many countries as ephedrone, is a synthetic potent stimulant that is a structural analogue of methamfetamine and is related to cathinone. All these drugs have primarily psychostimulant properties and are also vasoconstrictors to a varying degree. They induce euphoria and hyperactivity, as may be seen in stimulant intoxication. They have potent dependence-producing properties, which may lead to the diagnosis of stimulant dependence and stimulant withdrawal following the cessation of use. Several stimulant-induced mental disorders are described. Stimulants are a widespread cause of hospitalization and clinic attendance, and significant causes of morbidity and mortality, often due to violence related to stimulant-induced psychotic disorder.

6C47 Disorders due to use of synthetic cathinones

Disorders due to use of synthetic cathinones are characterized by the pattern and consequences of synthetic cathinone use. Synthetic cathinones (also known as "bath salts") are synthetic compounds with stimulant properties related to cathinone found in the khat plant, *Catha edulis*. The use of synthetic cathinones is common in young populations in many countries. They may produce a range of disorders including synthetic cathinone intoxication, synthetic cathinone dependence and synthetic cathinone withdrawal. Several synthetic cathinone-induced mental disorders are recognized.

6C48 Disorders due to use of caffeine

Disorders due to use of caffeine are characterized by the pattern and consequences of caffeine use. Caffeine is a mild psychostimulant and diuretic that is found in the beans of the coffee plant (*Coffea* species), and is a constituent of coffee, cola drinks, chocolate, a range of proprietary "energy drinks" and weight-loss aids. It is the most commonly used psychoactive substance worldwide, and several clinical conditions related to its use are described, although severe disorders are comparatively rare considering its ubiquity. Caffeine intoxication related to consumption of relatively high doses (i.e. >1 g per day) is described. Caffeine withdrawal is common upon cessation of use among individuals who have used caffeine for a prolonged period or in large amounts. Caffeine-induced anxiety disorder has been described, often following intoxication or heavy use.

6C49 Disorders due to use of hallucinogens

Disorders due to use of hallucinogens are characterized by the pattern and consequences of hallucinogen use. Several thousand compounds have hallucinogenic properties, many of which are found in plants (e.g. mescaline) and fungi (e.g. psilocybin) or are chemically synthesized (e.g. LSD). These compounds have primarily hallucinogenic properties, but some may also be stimulants. Much of the morbidity associated with these compounds arises from the acute effects related to hallucinogen intoxication. Hallucinogen dependence is rare, and hallucinogen withdrawal is not described. Among the mental disorders related to hallucinogen use, hallucinogen-induced psychotic disorder is the most frequently seen, although worldwide it is still fairly uncommon.

6C4A Disorders due to use of nicotine

Disorders due to use of nicotine are characterized by the pattern and consequences of nicotine use. Nicotine is the active dependence-producing constituent of the tobacco plant, *Nicotiana tabacum*. Nicotine is used overwhelmingly through smoking cigarettes. Increasingly, it is also used in electronic cigarettes that vaporize nicotine dissolved in a carrier solvent for inhalation (i.e. "vaping"). Pipe smoking, chewing tobacco and inhaling snuff are minor forms of use. Nicotine is a highly potent addictive compound, and is the third most common psychoactive substance used worldwide after caffeine and alcohol. Nicotine dependence and nicotine withdrawal are well described, and nicotine-induced mental disorders are recognized. Tobacco is by far the most important cause worldwide of morbidity and mortality of all the psychoactive substances; this is due in part to its addictive constituent nicotine but more so to other constituents such as carcinogens and other hazardous and harmful compounds that are inhaled during smoking. Tobacco smoking is the leading cause of ill health and premature death among men, and is among the top 10 causes in women.

6C4B Disorders due to use of volatile inhalants

Disorders due to use of volatile inhalants are characterized by the pattern and consequences of volatile inhalant use. Volatile inhalants include a range of compounds that are in the gaseous or vapour phase at ambient temperatures, such as various organic solvents, glues, gasoline (petrol), nitrites and gases such as nitrous oxide, trichloroethane, butane, toluene, fluorocarbons, ether and halothane. They have a range of pharmacological properties but are predominantly central nervous system depressants, with many also having vasoactive effects. They tend to be used by younger people, and may be used when access to alternative psychoactive substances is difficult or impossible. Volatile inhalant intoxication is well recognized. Volatile inhalants have dependence-producing properties, and volatile inhalant dependence and volatile inhalant withdrawal are recognized, although comparatively uncommon worldwide. Volatile inhalant-induced mental disorders are described. Volatile inhalants may also cause neurocognitive impairment, including dementia.

6C4C Disorders due to use of MDMA or related drugs, including MDA

Disorders due to use of 3,4-Methylenedioxymethamfetamine (MDMA) or related drugs, including methylenedioxyamfetamine (MDA), are characterized by the pattern and consequences of MDMA or related drug use. MDMA is a common drug of abuse in many countries especially among young people. It is predominantly available in tablet form known as "ecstasy". Pharmacologically, MDMA has stimulant and empathogenic properties, and these encourage its use among young people for social and other interactions. Considering its wide prevalence in many countries and among many subgroups of young people, MDMA and related drug dependence and MDMA and related drug withdrawal are comparatively uncommon. Substance-induced mental disorders may arise from its use, and health sequelae are recognized, including liver disease and hyponatraemia, which may be fatal. Several analogues of MDMA exist, including MDA.

6C4D Disorders due to use of dissociative drugs, including ketamine and phencyclidine (PCP)

Disorders due to use of dissociative drugs, including ketamine and PCP, are characterized by the pattern and consequences of dissociative drug use. Dissociative drugs include ketamine and PCP and their (comparatively rare) chemical analogues. Ketamine is an intravenous anaesthetic widely used in low- and middle-income countries, particularly in Africa, and in emergency situations. Ketamine is also undergoing evaluation for treatment of some mental disorders (e.g. treatment-resistant depressive disorders). It is also a widespread drug of nonmedical use in many countries, and may be taken by the oral or nasal routes or injected. It produces a sense of euphoria but, depending on the dose, emergent hallucinations and dissociation are recognized as unpleasant side-effects. Phencyclidine has a more restricted worldwide distribution, and also has euphoric and dissociative effects. Its use may result in bizarre behaviour uncharacteristic for the individual, including self-harm. Dissociative drug dependence is described, but a withdrawal syndrome is not recognized by most authorities. Several dissociative drug-induced mental disorders are recognized.

6C4E Disorders due to use of other specified psychoactive substances, including medications

Disorders due to use of other specified psychoactive substances, including medications, are characterized by the pattern and consequences of psychoactive substances that are not included among the major substance classes specifically identified above. Examples include khat, anabolic steroids, antidepressants, medications with anticholinergic properties (e.g. benztropine) and some antihistamines.

6C4F Disorders due to use of multiple specified psychoactive substances, including medications

The categories in this grouping are provided for coding purposes. However, in most clinical situations it is recommended that multiple categories from disorders due to substance use should be assigned if these can be discerned, rather than using categories from this grouping. Doing so will provide more useful information for both clinical and coding purposes.

6C4G Disorders due to use of unknown or unspecified psychoactive substances

These categories apply in clinical situations in which it is clear that the disturbance is due to substance use but the specific substance or class of substances is initially unknown. As more information becomes available (e.g. laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the relevant substance or substance class.

6C4H Disorders due to use of non-psychoactive substances

Disorders due to use of non-psychoactive substances are characterized by the pattern and consequences of nonmedical use of non-psychoactive substances. Non-psychoactive substances include laxatives, growth hormone, erythropoietin and non-steroidal anti-inflammatory drugs. They may also include proprietary or over-the-counter medicines and folk remedies. Nonmedical use of these substances may be associated with harm to the individual due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration (e.g. infections due to intravenous self-administration). They are not associated with intoxication or with a dependence or withdrawal syndrome, and are not recognized causes of substance-induced mental disorders.

6C4Z Disorders due to substance use, unspecified

Diagnostic categories that apply to the various classes of psychoactive substances

Specific diagnostic categories that apply to the classes of psychoactive substances listed above are as follows:

- Episode of harmful psychoactive substance use
- Harmful pattern of psychoactive substance use
- Substance dependence
- Substance intoxication
- Substance withdrawal
- Substance-induced delirium
- Substance-induced psychotic disorder
- Substance-induced mood disorder
- Substance-induced anxiety disorder
- Substance-induced obsessive-compulsive or related disorder
- Substance-induced impulse control disorder
- Other specified disorder due to substance use
- Disorder due to substance use, unspecified.

Additional categories of disorders induced by psychoactive substances are included in other parts of this chapter on mental, behavioural and neurodevelopmental disorders. These categories relate to substance-induced catatonia, substance-induced amnestic disorder and substance-induced dementia. They are cross-listed in the section below on substance-induced mental disorders for reference.

Note that not all possible combinations of disorder and substance class are included in the classification. For example, there is no category for substance withdrawal due to dissociative drugs, including ketamine and PCP, and no category for nicotine-induced psychotic disorder. Allowable categories by substance class for episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use, substance dependence, substance intoxication and substance withdrawal are shown in Table 6.13 (p. 450). Allowable categories by substance class for substance-induced mental disorders (substance-induced delirium, substance-induced psychotic disorder, substance-induced mood disorder, substance-induced anxiety disorder, substance-induced obsessive-compulsive or related disorder and substance-induced impulse control disorder) are shown in Table 6.14 (p. 454).

CDDR are provided below for each type of disorder, together with a list of applicable substance classes. Information specific to particular substance classes is also provided when applicable.

The first three diagnoses listed above (episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use and substance dependence) describe the use pattern of the substance. One of these three diagnoses – or disorder due to substance use, unspecified, for cases in which the use pattern in unknown at the time of evaluation – is considered to be the primary diagnosis. That is, one of these four diagnoses should be assigned when making a diagnosis of a disorder due to substance use.

The remaining diagnoses reflect the impact of the substance use pattern, and are thus considered to be associated with one of the primary use pattern diagnoses. These diagnoses should therefore be assigned together with the relevant primary diagnosis. For example, 6C49.1/6C49.5 is harmful pattern of use of hallucinogens associated with hallucinogen-induced psychotic disorder, 6C43.2/6C43.70 is opioid dependence associated with opioid-induced mood disorder, and 6C4Z/6C40.3 is disorder due to substance use, unspecified, associated with alcohol intoxication (i.e. the pattern of use in this last case is unknown).

Also listed in this section are categories related to hazardous substance use. These categories are not considered to be mental disorders, but may be used when the pattern of substance use appreciably increases the risk of harmful physical or mental health consequences, to the user or to others, to an extent that warrants attention and advice from health professionals, but no overt harm has yet occurred.

Table 6.13. Applicable disorders due to substance use by substance class

	Episode of harmful psychoactive substance use	Harmful pattern of psychoactive substance use[a]	Substance dependence[b]	Substance intoxication	Substance withdrawal[c]
Alcohol	6C40.0	6C40.10 E 6C40.11 C	6C40.20 C 6C40.21 E 6C40.22 EF 6C40.23 SP 6C40.24 SF	6C40.3	6C40.40 U 6C40.41 PD 6C40.42 S 6C40.43 PD&S
Cannabis	6C41.0	6C41.10 E 6C41.11 C	6C41.20 C 6C41.21 EF 6C41.22 SP 6C41.23 SF	6C41.3	6C41.4
Synthetic cannabinoids	6C42.0	6C42.10 E 6C42.11 C	6C42.20 C 6C42.21 EF 6C42.22 SP 6C42.23 SF	6C42.3	6C42.4
Opioids	6C43.0	6C43.10 E 6C43.11 C	6C43.20 C 6C43.21 EF 6C43.22 SP 6C43.23 SF	6C43.3	6C43.4

Table 6.13. contd

	Episode of harmful psychoactive substance use	Harmful pattern of psychoactive substance use[a]	Substance dependence[b]	Substance intoxication	Substance withdrawal[c]
Sedatives, hypnotics or anxiolytics	6C44.0	6C44.10 E 6C44.11 C	6C44.20 C 6C44.21 EF 6C44.22 SP 6C44.23 SF	6C44.3	6C44.40 U 6C44.41 PD 6C44.42 S 6C44.43 PD&S
Cocaine	6C45.0	6C45.10 E 6C45.11 C	6C45.20 C 6C45.21 EF 6C45.22 SP 6C45.23 SF	6C45.3	6C45.4
Stimulants, including amfetamines, methamfetamine and methcathinone	6C46.0	6C46.10 E 6C46.11 C	6C46.20 C 6C46.21 EF 6C46.22 SP 6C46.23 SF	6C46.3	6C46.4
Synthetic cathinones	6C47.0	6C47.10 E 6C47.11 C	6C47.20 C 6C47.21 EF 6C47.22 SP 6C47.23 SF	6C47.3	6C47.4
Caffeine	6C48.0	6C48.10 E 6C48.11 C	N/A	6C48.2	6C48.3
Hallucinogens	6C49.0	6C49.10 E 6C49.11 C	6C49.20 C 6C49.21 EF 6C49.22 SP 6C49.23 SF	6C49.3	N/A

Table 6.13. contd

	Episode of harmful psychoactive substance use	Harmful pattern of psychoactive substance use[a]	Substance dependence[b]	Substance intoxication	Substance withdrawal[c]
Nicotine	6C4A.0	6C4A.10 E 6C4A.11 C	6C4A.20 C 6C4A.21 EF 6C4A.22 SP 6C4A.23 SF	6C4A.3	6C4A.4
Volatile inhalants	6C4B.0	6C4B.10 E 6C4B.11 C	6C4B.20 C 6C4B.21 EF 6C4B.22 SP 6C4B.23 SF	6C4B.3	6C4B.4
MDMA or related drugs, including MDA	6C4C.0	6C4C.10 E 6C4C.11 C	6C4C.20 C 6C4C.21 EF 6C4C.22 SP 6C4C.23 SF	6C4C.3	6C4C.4
Dissociative drugs, including ketamine and PCP	6C4D.0	6C4D.10 E 6C4D.11 C	6C4D.20 C 6C4D.21 EF 6C4D.22 SP 6C4D.23 SF	6C4D.3	N/A
Other specified	6C4E.0	6C4E.10 E 6C4E.11 C	6C4E.20 C 6C4E.21 EF 6C4E.22 SP 6C4E.23 SF	6C4E.3	6C4E.40 U 6C4E.41 PD 6C4E.42 S 6C4E.43 PD&S
Multiple specified	6C4F.0	6C4F.10 E 6C4F.11 C	6C4F.20 C 6C4F.21 EF 6C4F.22 SP 6C4F.23 SF	6C4F.3	6C4F.40 U 6C4F.41 PD 6C4F.42 S 6C4F.43 PD&S

Table 6.13. contd

	Episode of harmful psychoactive substance use	Harmful pattern of psychoactive substance use[a]	Substance dependence[b]	Substance intoxication	Substance withdrawal[c]
Unknown or unspecified	6C4G.0	6C4G.10 E	6C4G.20 C	6C4G.3	6C4G.40 U
		6C4G.11 C	6C4G.21 EF		6C4G.41 PD
			6C4G.22 SP		6C4G.42 S
			6C4G.23 SF		6C4G.43 PD&S
Non-psychoactive	6C4H.0	6C4H.10 E	N/A	N/A	N/A
		6C4H.11 C			

[a] E = episodic; C = continuous

[b] E = episodic; C = continuous; EF = early full remission; SP = sustained partial remission; SF = sustained full remission

[c] U = uncomplicated; PD = with perceptual disturbances; S = with seizures; PD&S = with perceptual disturbances and seizures

Table 6.14. Applicable substance-induced mental disorders by substance class

	Delirium	Psychotic[a]	Mood	Anxiety	Obsessive-compulsive	Impulse control	Amnestic	Dementia
Alcohol	6C40.5	6C40.60 H 6C40.61 D 6C40.62 M	6C40.70	6C40.71	N/A	N/A	6D72.10	6D84.0
Cannabis	6C41.5	6C41.6	6C41.70	6C41.71	N/A	N/A	N/A	N/A
Synthetic cannabinoids	6C42.5	6C42.6	6C42.70	6C42.71	N/A	N/A	N/A	N/A
Opioids	6C43.5	6C43.6	6C43.70	6C43.71	N/A	N/A	N/A	N/A
Sedatives, hypnotics or anxiolytics	6C44.5	6C44.6	6C44.70	6C44.71	N/A	N/A	6D72.11	6D84.1
Cocaine	6C45.5	6C45.60 H 6C45.61 D 6C45.62 M	6C45.70	6C45.71	6C45.72	6C45.73	N/A	N/A
Stimulants, including amfetamines, methamfetamine and methcathinone	6C46.5	6C46.60 H 6C46.61 D 6C46.62 M	6C46.70	6C46.71	6C46.72	6C46.73	N/A	N/A
Synthetic cathinones	6C47.5	6C47.60 H 6C47.61 D 6C47.62 M	6C47.70	6C47.71	6C47.72	6C47.73	N/A	N/A
Caffeine	N/A	N/A	N/A	6C48.40	N/A	N/A	N/A	N/A
Hallucinogens	6C49.4	6C49.5	6C49.60	6C49.61	N/A	N/A	N/A	N/A
Nicotine	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Volatile inhalants	6C4B.5	6C4B.6	6C4B.70	6C4B.71	N/A	N/A	6D72.13	6D84.2
MDMA or related drugs, including MDA	6C4C.5	6C4C.6	6C4C.70	6C4C.71	N/A	N/A	N/A	N/A
Dissociative drugs, including ketamine and PCP	6C4D.4	6C4D.5	6C4D.60	6C4D.61	N/A	N/A	N/A	N/A
Other specified	6C4E.5	6C4E.6	6C4E.70	6C4E.71	6C4E.72	6C4E.73	6D72.12	6D84.Y
Multiple specified	6C4F.5	6C4F.6	6C4F.70	6C4F.71	6C4F.72	6C4F.73	N/A	N/A
Unknown or unspecified	6C4G.5	6C4G.6	6C4G.70	6C4G.71	6C4G.72	6C4G.73	N/A	N/A
Non-psychoactive	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[a] H = with hallucinations, D = with delusions, M = with mixed psychotic symptoms

Diagnostic requirements for disorders due to substance use

Episode of harmful psychoactive substance use

Available categories by substance class

6C40.0	Episode of harmful use of alcohol
6C41.0	Episode of harmful use of cannabis
6C42.0	Episode of harmful use of synthetic cannabinoids
6C43.0	Episode of harmful use of opioids
6C44.0	Episode of harmful use of sedatives, hypnotics or anxiolytics
6C45.0	Episode of harmful use of cocaine
6C46.0	Episode of harmful use of stimulants, including amfetamines, methamfetamine and methcathinone
6C47.0	Episode of harmful use of synthetic cathinones
6C48.0	Episode of harmful use of caffeine
6C49.0	Episode of harmful use of hallucinogens
6C4A.0	Episode of harmful use of nicotine
6C4B.0	Episode of harmful use of volatile inhalants
6C4C.0	Episode of harmful use of MDMA or related drugs, including MDA
6C4D.0	Episode of harmful use of dissociative drugs, including ketamine and PCP
6C4E.0	Episode of harmful use of other specified psychoactive substance
6C4F.0	Episode of harmful use of multiple specified psychoactive substances, including medications
6C4G.0	Episode of harmful use of unknown or unspecified psychoactive substances

Essential (required) features

- An episode of use of a psychoactive substance that has caused clinically significant damage to a person's physical health (e.g. bloodborne infection from intravenous self-administration) or mental health (e.g. substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others, is required for diagnosis.
- Harm to the health of the individual occurs due to one or more of the following: behaviour related to intoxication (see Table 6.15, p. 475); direct or secondary toxic effects on body organs and systems; or a harmful route of administration.
- Harm to the health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of episode of harmful psychoactive substance use applies.

- The harm to health is not better accounted for by another medical condition or another mental disorder, including another disorder due to substance use (e.g. substance withdrawal).

Note: harm to the health of the person to whom the diagnosis applies includes injuries caused by behaviour related to intoxication (e.g. impulsive aggressive behaviour, psychomotor impairment leading to injury; see Table 6.15, p. 475), acute health problems resulting from substance use (e.g. overdose, acute gastritis, the effects of hypoxia or prolonged hyperactivity or inactivity), and exacerbation or decompensation of pre-existing chronic health problems (e.g. hypertension, liver disease or peptic ulceration). Harm may also result from a harmful route of administration (e.g. injecting drug use causing bloodborne virus infections, cocaine use causing a perforated nasal septum). The relevant diagnostic codes from other ICD-11 chapters – including Chapter 22 on injury, poisoning or certain other consequences of external causes – should be used to describe the specific health consequences of the harmful substance use.

Harm to the health of others includes any form of physical harm, including trauma (e.g. impaired driving causing a motor vehicle accident, assaultive behaviour leading to bodily harm to another person) or mental disorder (e.g. post-traumatic stress disorder arising from an assault by the intoxicated individual) that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of episode of harmful psychoactive substance use applies.

Additional clinical features

- There must be explicit evidence of harm to the individual's physical or mental health, or of substance-related behaviour due to intoxication that has led to harm to the physical or mental health of others. There must also be a clear causal relationship between the harm to health and the episode of substance use in question.
- The likelihood of harm to self or others due behaviour related to intoxication varies substantially by substance (see Table 6.15, p. 475). For example, such behaviour is unlikely to arise from caffeine or nicotine intoxication.
- Psychoactive substance use commonly occurs in the context of other mental disorders. An additional diagnosis of episode of harmful psychoactive substance use can be made if the index episode of substance use has resulted in clinically significant harm to the individual's physical health, or has exacerbated or triggered an episode of a pre-existing mental disorder (e.g. a manic or depressive episode or a psychotic episode).
- A diagnosis of episode of harmful psychoactive substance use often signals an opportunity for intervention – typically a low-intensity intervention that can be implemented in a wide range of settings, which is specifically aimed at reducing the likelihood of additional harmful episodes or of progression to harmful pattern of use or substance dependence.
- A diagnosis of episode of harmful psychoactive substance use of unknown or unspecified psychoactive substances can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g. laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for the episode of harm.
- As more information becomes available indicating that the episode is part of a continuous or recurrent pattern of substance use, or if additional harmful episodes occur, a diagnosis of episode of harmful psychoactive substance use should be changed to harmful pattern of psychoactive substance use or substance dependence, as appropriate.

Boundary with normality (threshold)

- The diagnosis of episode of harmful psychoactive substance use requires clinically significant harm to the individual's physical or mental health or the health of others. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting, or transient depressed mood.
- A range of social problems may be associated with an episode of substance use that are not sufficiently severe to constitute clinically significant harm to physical or mental health (e.g. missed appointments, arguments with loved ones). Such problems are not a sufficient basis for a diagnosis of episode of harmful psychoactive substance use.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hazardous substance use

Hazardous substance use is classified in Chapter 24 on factors influencing health status or contact with health services and not in this chapter on mental, behavioural and neurodevelopmental disorders. Hazardous substance use appreciably increases the risk of harmful physical or mental health consequences, to the user or to others, to an extent that warrants attention and advice from health professionals, but has not resulted in specific identifiable harm and therefore does not meet the diagnostic requirements for episode of harmful psychoactive substance use.

Boundary with harmful pattern of psychoactive substance use

If the harm to health is a result of a known episodic or continuous pattern of substance use, and all other diagnostic requirements are met, a diagnosis of harmful pattern of psychoactive substance use should be assigned. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months. If harm is caused by use of a substance but no information is available about the pattern or history of substance use, a diagnosis of episode of harmful psychoactive substance use may be assigned until such time as evidence for a pattern of use is ascertained.

Boundary with substance dependence

In substance dependence, individuals use a substance or substances persistently, despite harm and adverse consequences. Harm caused by such use may be similar to that observed in episode of harmful psychoactive substance use. However, substance dependence also includes additional features of impaired ability to control use and increasing priority given to the substance use over other activities. Physiological features (e.g. tolerance) may also be present for applicable substances. If all diagnostic requirements for substance dependence are met for a particular substance, episode of harmful psychoactive substance use should not be assigned for that substance. ***Note:*** substance dependence is only applicable for some substances or substance classes (see Table 6.13, p. 450).

Boundary with substance intoxication

Substance intoxication is defined by substance use that results in clinically significant transient substance-specific symptoms (see Table 6.15, p. 475). Recovery from substance intoxication is generally complete and without physical or mental sequelae. If there is continuing damage or harm (e.g. the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, tissue damage) due to an episode of substance intoxication, a diagnosis of episode of harmful psychoactive substance use may be assigned. If relevant at the time of the clinical encounter (e.g. in emergency settings), episode of harmful psychoactive substance use may be diagnosed with an associated diagnosis of substance intoxication.

Boundary with substance-induced mental disorders

Substance-induced mental disorders can be associated with a single episode of substance use. If a substance-induced mental disorder has occurred as a form of harm resulting from a single episode of substance use, both episode of harmful psychoactive substance use and the relevant substance-induced mental disorder should be diagnosed (e.g. episode of harmful cocaine use with cocaine-induced psychotic disorder). ***Note:*** specific substance-induced mental disorders are only applicable for some substances or substance classes (see Table 6.14, p. 454).

Boundary with overdose

When ingestion of psychoactive substances results in symptoms of overdose (e.g. coma, life-threatening cardiac or respiratory suppression), a diagnosis from the grouping of harmful effects of substances in Chapter 22 on injury, poisoning or certain other consequences of external causes should also be assigned.

Harmful pattern of psychoactive substance use

Available categories by substance class

6C40.1	Harmful pattern of use of alcohol
6C41.1	Harmful pattern of use of cannabis
6C42.1	Harmful pattern of use of synthetic cannabinoids
6C43.1	Harmful pattern of use of opioids
6C44.1	Harmful pattern of use of sedatives, hypnotics or anxiolytics
6C45.1	Harmful pattern of use of cocaine
6C46.1	Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone
6C47.1	Harmful pattern of use of synthetic cathinones
6C48.1	Harmful pattern of use of caffeine
6C49.1	Harmful pattern of use of hallucinogens
6C4A.1	Harmful pattern of use of nicotine
6C4B.1	Harmful pattern of use of volatile inhalants
6C4C.1	Harmful pattern of use of MDMA or related drugs, including MDA
6C4D.1	Harmful pattern of use of dissociative drugs, including ketamine and PCP
6C4E.1	Harmful pattern of use of other specified psychoactive substance
6C4F.1	Harmful pattern of use of multiple specified psychoactive substances
6C4G.1	Harmful pattern of use of unknown or unspecified psychoactive substances

Essential (required) features

- A pattern of continuous, recurrent or sporadic use of a psychoactive substance that has caused clinically significant damage to a person's physical health (e.g. bloodborne infection from intravenous self-administration) or mental health (e.g. substance-induced mood disorder), or has resulted in behaviour leading to harm to the health of others is required for diagnosis.
- Harm to the health of the individual occurs due to one or more of the following: behaviour related to intoxication (see Table 6.15, p. 475); direct or secondary toxic effects on body organs and systems; or a harmful route of administration.
- Harm to the health of others includes any form of physical harm, including trauma, or mental disorder that is directly attributable to behaviour related to substance intoxication on the part of the person to whom the diagnosis of harmful pattern of psychoactive substance use applies.
- The pattern of use of the relevant substance is evident over a period of at least 12 months if substance use is episodic, or at least 1 month if use is continuous.
- The harm to health is not better accounted for by another medical condition or another mental disorder, including another disorder due to substance use (e.g. substance withdrawal).

Note: harm to the health of the person to whom the diagnosis applies includes injuries caused by behaviour related to intoxication (e.g. impulsive aggressive behaviour, psychomotor impairment leading to injury; see Table 6.15, p. 475); acute health problems resulting from substance use (e.g. overdose, acute gastritis, the effects of hypoxia or prolonged hyperactivity or inactivity), and exacerbation or decompensation of pre-existing chronic health problems (e.g. hypertension, liver disease, or peptic ulceration). Harm may also result from a harmful route of administration (e.g. injecting drug use causing bloodborne virus infections, cocaine use causing a perforated nasal septum). The relevant diagnostic codes from other ICD-11 chapters – including Chapter 22 on injury, poisoning or certain other consequences of external causes – should be used to describe the specific health consequences of the harmful substance use.

Harm to the health of others includes any form of physical harm, including trauma (e.g. impaired driving causing a motor vehicle accident, assaultive behaviour leading to bodily harm to another person) or mental disorder (e.g. post-traumatic stress disorder arising from an assault by the intoxicated individual) that is directly attributable to behaviour due to substance intoxication on the part of the person to whom the diagnosis of harmful pattern of psychoactive substance use applies.

Course specifiers

A specifier is used to further describe the harmful pattern of substance use, using a fifth-character code. The *x* below corresponds to the fourth-character code indicating the substance class (0 for alcohol, 1 for cannabis, 2 for synthetic cannabinoids and so on).

6C4*x*.10 Harmful pattern of psychoactive substance use, episodic

This category is assigned when all the diagnostic requirements for harmful pattern of psychoactive substance use are met, and there is evidence of a pattern of recurrent episodic or intermittent use of the relevant psychoactive substance over a period of at least 12 months that has caused clinically significant harm to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

6C4*x*.11 Harmful pattern of psychoactive substance use, continuous

This category is assigned when all the diagnostic requirements for harmful pattern of psychoactive substance use are met, and there is evidence of a pattern of continuous substance use (daily or almost daily) of the relevant psychoactive substance over a period of at least 1 month that has caused clinically significant harm to a person's physical or mental health or has resulted in behaviour leading to harm to the health of others.

6C4*x*.1Z Harmful pattern of psychoactive substance use, unspecified

Additional clinical features

- There must be explicit evidence of harm to the individual's physical or mental health, or of behaviour due to substance intoxication that has led to harm to the physical or mental health of others. There must also be a clear causal relationship between the harm to health and the episodic or continuous use of a substance.
- The likelihood of harm to self or others due behaviour related to intoxication varies substantially by substance (see Table 6.15, p. 475). For example, such behaviour is unlikely to arise from caffeine or nicotine intoxication.
- A diagnosis of harmful pattern of use of unknown or unspecified psychoactive substances can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g. laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance(s) involved in the harmful pattern of psychoactive substance use.
- As more information becomes available about symptoms and behaviours related to the pattern of substance use, as well as physiological features indicative of neuroadaptation

to the substance, the diagnosis may be changed to substance dependence if diagnostic requirements are met.

Boundary with normality (threshold)

- The diagnosis of harmful pattern of psychoactive substance use requires clinically significant harm to the individual's physical or mental health or the health of others. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangovers, brief episodes of vomiting, or transient depressed mood.
- A pattern of psychoactive substance use may cause a range of problems in functioning (e.g. missed appointments, arguments with loved ones) that are not sufficiently severe to constitute clinically significant harm to physical or mental health. Such problems are not a sufficient basis for a diagnosis of harmful pattern of psychoactive substance use.

Developmental presentations

- Harmful pattern of psychoactive substance use is often a characteristic of late adolescence and young adulthood, and injuries and the consequences of aggressive behaviour are particularly common in this age group.
- Harmful pattern of psychoactive substance use in older adults may cause injuries and fractures due to the combination of lowered tolerance, psychomotor impairment induced by a substance, and disorders associated with ageing such as osteoporosis and dementia.

Sex- and/or gender-related features

- The prevalence of harmful pattern of psychoactive substance use is higher in males, but the gender differential is smaller in countries where women play a greater role in the workforce. Gender differences in injuries and other forms of harm due to substance use are recognized.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hazardous substance use

Hazardous substance use is classified in Chapter 24 on factors influencing health status or contact with health services and not in this chapter on mental, behavioural and neurodevelopmental disorders. hazardous substance use appreciably increases the risk of harmful physical or mental health consequences, to the user or to others, to an extent that warrants attention and advice from

health professionals, but has not resulted in specific identifiable harm and therefore does not meet the diagnostic requirements for harmful pattern of psychoactive substance use.

Boundary with episode of harmful psychoactive substance use

If the harm to health is a result of a single episode of use rather than a pattern of substance use, whether episodic or continuous, a diagnosis of episode of harmful psychoactive substance use should be assigned. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months. If harm is caused by use of a substance but no information is available about the pattern or history of substance use, a diagnosis of episode of harmful psychoactive substance use may be assigned until such time as evidence for a pattern of use is ascertained.

Boundary with substance dependence

In substance dependence, individuals use a substance or substances persistently, despite harm and adverse consequences. Harm caused by such use may be similar to that observed in harmful pattern of psychoactive substance use. However, substance dependence also includes additional features of impaired ability to control use and increasing priority given to the substance use over other activities. Physiological features (e.g. tolerance) may also be present for applicable substances. If all diagnostic requirements for substance dependence are met for a particular substance, Harmful pattern of psychoactive substance use should not be assigned for that substance. ***Note:*** substance dependence is only applicable for some substances or substance classes (see Table 6.13, p. 450).

Boundary with substance intoxication

Substance intoxication is defined by substance use that results in clinically significantly, transient substance-specific symptoms (see Table 6.15, p. 475). Recovery from substance intoxication is generally complete and absent of physical or mental sequelae. A pattern or repeated intoxication may or may not result in harm to a person's physical or mental health or to the health of others. If there is continuing damage or harm (e.g. the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, tissue damage) as a result of repeated or continuous use of a psychoactive substance, a diagnosis of harmful pattern of psychoactive substance use may be assigned. If relevant at the time of the clinical encounter (e.g. in emergency settings), harmful pattern of psychoactive substance use may be diagnosed with an associated diagnosis of substance intoxication.

Boundary with substance withdrawal

Substance withdrawal occurs upon cessation or reduction of a substance in the context of physiological dependence, or when a substance has been taken for a prolonged period or in large amounts. Some features of substance withdrawal may include physical or mental harm (e.g. seizures, delusions, hallucinations, anxiety). If the symptoms are entirely explained by the withdrawal syndrome for the relevant substance (see Table 6.16, p. 484), an additional diagnosis of harmful pattern of psychoactive substance use is not warranted. However, if the symptoms substantially exceed the expected withdrawal syndrome in duration or type or severity, and the diagnostic requirements for substance dependence are not met, harmful pattern of psychoactive substance use can be assigned as the primary diagnosis, with an associated diagnosis of substance withdrawal (e.g. harmful pattern of use of opioids with opioid withdrawal). ***Note:*** substance withdrawal is only applicable for some substances or substance classes (see Table 6.13, p. 450).

Boundary with substance-induced mental disorders

If a substance-induced mental disorder has occurred as a form of harm resulting from a pattern of substance use, both harmful pattern of psychoactive substance use and the relevant substance-induced mental disorder should be diagnosed (e.g. harmful pattern of cocaine use with cocaine-induced anxiety disorder). ***Note:*** specific substance-induced mental disorders are only applicable for some substances or substance classes (see Table 6.14, p. 454).

Boundary with other mental disorders and other medical conditions

Numerous mental disorders and subthreshold symptoms may co-occur with episodic or continuous patterns of substance use. Similarly, continuous or episodic substance use increases the risk of mental disorders and other medical conditions. Co-occurring mental disorders and comorbid medical conditions should be diagnosed separately, along with a diagnosis of harmful pattern of psychoactive substance use.

Substance dependence

Available categories by substance class

6C40.2	Alcohol dependence
6C41.2	Cannabis dependence
6C42.2	Synthetic cannabinoid dependence
6C43.2	Opioid dependence
6C44.2	Sedative, hypnotic or anxiolytic dependence
6C45.2	Cocaine dependence
6C46.2	Stimulant dependence, including amfetamines, methamfetamine and methcathinone
6C47.2	Synthetic cathinone dependence
6C49.2	Hallucinogen dependence
6C4A.2	Nicotine dependence
6C4B.2	Volatile inhalant dependence
6C4C.2	MDMA or related drug dependence, including MDA
6C4D.2	Dissociative drug dependence, including ketamine and PCP
6C4E.2	Other specified psychoactive substance dependence
6C4F.2	Multiple specified psychoactive substance dependence
6C4G.2	Unknown or unspecified psychoactive substance dependence

Essential (required) features

- A pattern of recurrent episodic or continuous use of a psychoactive substance is required for diagnosis, with evidence of impaired regulation of use of that substance that is manifested in two or more of the following:
  - impaired control over substance use (i.e. onset, frequency, intensity, duration, termination, context);
  - increasing precedence of substance use over other aspects of life, including maintenance of health, and daily activities and responsibilities, such that substance use continues or escalates despite the occurrence of harm or negative consequences (e.g. repeated relationship disruption, occupational or scholastic consequences, negative impact on health);
  - physiological features indicative of neuroadaptation to the substance, including tolerance to the effects of the substance or a need to use increasing amounts of the substance to achieve the same effect; withdrawal symptoms following cessation or reduction in use of that substance; or repeated use of the substance or

pharmacologically similar substances to prevent or alleviate withdrawal symptoms (substance-specific features of withdrawal are described in Table 6.16, p. 484). ***Note:*** physiological features are only applicable for certain substances.

- The features of dependence are usually evident over a period of at least 12 months, but the diagnosis may be made if use is continuous (daily or almost daily) for at least 3 months.

Course specifiers for alcohol dependence

For alcohol, a specifier is used to describe the pattern of substance use or remission. Unlike for other substances, a distinction is made between continuous and episodic use, as follows.

6C40.20 Alcohol dependence, current use, continuous

The individual exhibits alcohol dependence, with continuous consumption of alcohol (daily or almost daily) during at least the past month.

6C40.21 Alcohol dependence, current use, episodic

The individual exhibits alcohol dependence, with use during the past month and a history of intermittent heavy drinking, with periods of abstinence during the past 12 months.

6C40.22 Alcohol dependence, early full remission

After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from alcohol during a period lasting between 1 and 12 months.

6C40.23 Alcohol dependence, sustained partial remission

After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in alcohol consumption for more than 12 months, such that even though intermittent or continuing drinking has occurred during this period, the definitional requirements for dependence have not been met.

6C40.24 Alcohol dependence, sustained full remission

After a diagnosis of alcohol dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from alcohol for 12 months or longer.

6C40.2Z Alcohol dependence, unspecified

Course specifiers for substance dependence for substances other than alcohol

For all psychoactive substance classes other than alcohol (see the list above and Table 6.13, p. 450), a specifier is used to further describe the pattern of substance use or remission in the context of substance dependence, using a fifth-character code. Unlike alcohol, separate codes for continuous and episodic current use are not provided. The *x* below corresponds to the fourth-character code indicating the substance class (1 for cannabis, 2 for synthetic cannabinoids and so on).

6C4*x*.20 Substance dependence, current use

The individual exhibits current substance dependence, with episodic or continuous use of the substance within the past month.

6C4*x*.21 Substance dependence, early full remission

After a diagnosis of substance dependence, and often following a treatment episode or other intervention (including self-help intervention), the individual has been abstinent from the substance during a period lasting between 1 and 12 months.

6C4*x*.22 Substance dependence, sustained partial remission

After a diagnosis of substance dependence, and often following a treatment episode or other intervention (including self-help intervention), there is a significant reduction in substance use for more than 12 months, such that even though intermittent or continuous use has occurred during this period, the diagnostic requirements for dependence have not been met.

6C4*x*.23 Substance dependence, sustained full remission

After a diagnosis of substance dependence, and often following a treatment episode or other intervention (including self-intervention), the person has been abstinent from the substance for 12 months or longer.

6C4*x*.2Z Substance dependence, unspecified

Additional clinical features for substance dependence

- A subjective sensation of urge or craving to use the substance often, but not always, accompanies the essential features of substance dependence.
- When present as an aspect of substance dependence, withdrawal symptoms must be consistent with the known withdrawal state for that substance (see Table 6.16, p. 484). Onset and course of withdrawal are time-limited, and are related to the type of substance and the dose used immediately before cessation or reduction in amount.
- Tolerance varies as a function of individual factors (e.g. substance use history, genetics) and should be differentiated from initial levels of response during intoxication, which also exhibit significant individual variability. Laboratory testing that reveals high levels of the substance in bodily fluids with no evidence of significant symptoms of intoxication may be suggestive of tolerance. Tolerance to the effects of substances as indicated by different psychophysiological responses can develop at varying rates (e.g. tolerance to respiratory depression caused by opioid intoxication may develop prior to tolerance to the sedating effects of the drug). With abstinence, tolerance effects diminish over time.
- Individuals with certain comorbid medical conditions (e.g. chronic liver disease) typically have reduced tolerance to substances.
- Physical or mental health consequences (beyond the essential features of substance dependence) typically occur in people with substance dependence, but are not required for the diagnosis. Similarly, functional impairment in one or several domains of life (e.g. work, domestic responsibilities, child-rearing) is commonly seen in people with substance dependence, but is not required in order to assign the diagnosis.
- Individuals with substance dependence have elevated rates of many other mental disorders, including conduct-dissocial disorder, attention deficit hyperactivity disorder, impulse control disorders, post-traumatic stress disorder, social anxiety disorder, generalized anxiety disorder, mood disorders, psychotic disorders and personality disorder with prominent dissocial features, as well as subthreshold symptoms. The specific pattern of co-occurrence depends on the substance involved, and reflects common risk factors and common causal pathways. These are distinguished from substance-induced mental disorders, in which the symptoms are a result of the direct physiological effects of the substance on the central nervous system.
- A pattern of substance use that includes frequent or high dose administration occurs more often among certain subgroups (e.g. adolescents). In these cases, peer-group dynamics may contribute to the maintenance of substance use. Regardless of the social contributions to the behaviour, a pattern of substance use that is consistent with subgroup norms should not be considered as presumptive evidence of substance dependence unless all diagnostic requirements for the disorder are met.

Boundary with normality (threshold)

- Frequent or even daily substance use of a substance does not automatically imply a diagnosis of substance dependence. There must also be evidence of the essential features of substance dependence, such as impaired control over use, increasing precedence of use over other life priorities or physiological features.
- The presence of physiological features such as tolerance and withdrawal is sometimes referred to as "physiological dependence". These features may occur, for example, in response to prolonged therapeutic use of certain medications, such as in patients who are appropriately prescribed opioid analgesics for cancer pain. By themselves, however, these features are not sufficient for a diagnosis of substance dependence, which also requires either impaired control over substance use or increasing precedence of substance use over other activities.

Course features

- The course of substance dependence varies by substance, frequency, intensity and duration of use. The central features of the dependence syndrome may be overshadowed by the harms to physical and mental health that patients with dependence often experience, and for which they frequently seek treatment. Numerous medical conditions can occur due to substance use in the course of substance dependence. These conditions tend to be specific for each substance, although some are shared across substances. Negative consequences to physical health reflect the known pharmacological effects of the relevant substance, the toxic effects of the substance on tissues and organs, or the route of administration (e.g. intravenous self-administration). Examples include alcoholic cirrhosis, infective endocarditis and HIV/AIDS. Medical conditions caused by substance use should be diagnosed separately.

Developmental presentations

- Substance dependence may develop more rapidly during adolescence than is usual during adulthood, especially when there are familial or other risk factors for substance dependence.
- Tolerance to psychoactive substances may develop rapidly in adolescents and young adults, and may decline equally rapidly when substance use ceases or is reduced in quantity or frequency.
- Withdrawal symptoms are well recognized in neonates born to women with substance dependence who have used psychoactive substances during pregnancy. However, the presence of a withdrawal state in a neonate should not be the sole basis for a diagnosis of substance dependence in the mother.
- Older adults often have reduced tolerance to substances.

Sex- and/or gender-related features

- Substance dependence has similar features in men and women, although the intensity of substance use and duration of use necessary to result in dependence may differ by sex. For example, alcohol dependence may occur after a lower cumulative alcohol intake in women compared to men because of sex-related differences in body mass and composition.
- Women are less likely to be involved with the legal system in relation to substance use, and therefore may be less likely to come to clinical attention than men. In clinical contexts, women may be reluctant to admit using substances due to prevailing social attitudes and proscriptions.
- In some societies it may be culturally unacceptable for women to admit to substance use. Specific probing may be necessary to elicit a history of substance use and dependence.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with substance intoxication

Episodic or continuous intoxication with substances is a typical feature of substance dependence, but is not an essential feature. Conversely, even if frequent and severe, substance intoxication alone is not a basis for a diagnosis of substance dependence. If all diagnostic requirements of both conditions are met for the same episode of care, substance dependence should be assigned as the primary diagnosis, with an associated diagnosis of substance intoxication (e.g. opioid dependence with opioid intoxication) if appropriate to the specific clinical situation (e.g. in emergency settings).

Boundary with harmful substance use

Substance dependence is often associated with physical and mental health consequences, such as those seen in harmful pattern of psychoactive substance use. In the absence of the essential features of substance dependence, a diagnosis of harmful substance use can be given when there has been demonstrable harm to the individual's physical or mental health or the health of others. Harmful pattern of psychoactive substance use and substance dependence should not be diagnosed together.

Boundary with substance withdrawal

Depending on the substance, many individuals with substance dependence develop substance withdrawal upon cessation or reduction in the amount of a substance consumed. In such cases, both substance dependence and substance withdrawal should be diagnosed. However, substance withdrawal can be diagnosed in the absence of a diagnosis of substance dependence – for example, in response to cessation of medically appropriate treatment with opioid analgesics that is not accompanied by the other essential features of substance dependence. ***Note:*** substance withdrawal is only applicable for some substances or substance classes (see Table 6.13, p. 450).

Boundary with substance-induced mental disorders

The impact of repeated or continuous use of substances characteristic of substance dependence may include substance-induced mental disorders, in which case both substance dependence and the relevant substance-induced mental disorder should be diagnosed (e.g. alcohol dependence with alcohol-induced delirium). ***Note:*** specific substance-induced mental disorders are only applicable for some substance classes (see Table 6.14, p. 454).

Substance intoxication

Available categories by substance class

6C40.3	Alcohol intoxication
6C41.3	Cannabis intoxication
6C42.3	Synthetic cannabinoid intoxication
6C43.3	Opioid intoxication
6C44.3	Sedative, hypnotic or anxiolytic intoxication
6C45.3	Cocaine intoxication
6C46.3	Stimulant intoxication, including amfetamines, methamfetamine and methcathinone
6C47.3	Synthetic cathinone intoxication
6C48.2	Caffeine intoxication
6C49.3	Hallucinogen intoxication
6C4A.3	Nicotine intoxication
6C4B.3	Volatile inhalant intoxication
6C4C.3	MDMA or related drug intoxication, including MDA
6C4D.3	Dissociative drug intoxication, including ketamine and PCP
6C4E.3	Other specified psychoactive substance intoxication
6C4F.3	Intoxication due to multiple specified psychoactive substances
6C4G.3	Intoxication due to unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by transient and clinically significant disturbances in consciousness, cognition, perception, affect, behaviour or coordination that develop during or shortly after the consumption or administration of a substance.
- The symptoms are compatible with the known pharmacological effects of the substance, and their intensity is closely related to the amount of the substance consumed.
- The symptoms of intoxication are time-limited, and abate as the substance is cleared from the body.
- Symptoms are not better accounted for by another medical condition (see Box 6.1) or another mental disorder, including another disorder due to substance use (e.g. substance withdrawal).

Note: Table 6.15 (p. 475) lists clinically important presenting features of substance intoxication attributable to the pharmacological effects of each substance class.

Box 6.1. Examples of medical conditions that may present with symptoms similar to substance intoxication

- Head injury (with or without cerebral contusion or intracranial haemorrhage or haematoma)
- Meningitis and encephalitis
- Diabetic ketoacidosis or hypoglycaemia
- Hepatic or other metabolic encephalopathy
- Wernicke's encephalopathy
- Electrolyte disturbance
- Hypoxia or hypercapnia
- Systemic infection

Severity of intoxication specifier

Depending on the specific clinical situation and the information available, substance intoxication may be classified according to the level of severity as mild, moderate or severe. The level of intoxication is usually related to the dose, route of administration, half-life and duration of action of the substance. Severity of intoxication is also affected by individual variability (e.g. differences in body weight, substance metabolism, tolerance). Susceptibility to substance intoxication may also be greater in individuals with comorbid medical conditions affecting drug pharmacokinetics (e.g. renal or hepatic insufficiency).

For some substances, there are specific tests for detecting and determining the concentration of substances in bodily fluids (e.g. blood, urine), which can be important tools for clinical management. However, severity of intoxication should be determined on the basis of clinical assessment, as specified below, and not solely based on the presence and level of the substance in bodily fluids.

The level of medical attention that may be required in response to substance intoxication varies according to the severity of intoxication and the substance involved, and varies from precautionary observation to urgent intervention to prevent death or permanent harm (e.g. administration of antagonist treatment, intubation).

Severity of intoxication can be rated as *mild* (XS5W), *moderate* (XS0T) or *severe* (XS25), using extension codes, in addition to the appropriate substance intoxication category.

To indicate severity, the code for the appropriate severity level is appended to the substance intoxication diagnostic code using an ampersand (&). For example, "6C43.3&XS25" is the code for opioid intoxication, severe.

XS5W Mild substance intoxication

Mild substance intoxication is a state in which there are clinically recognizable disturbances in psychophysiological functions and responses (e.g. motor coordination, attention and judgement) that vary by substance (see Table 6.15, p. 475), but there is little or no disturbance in the level of consciousness.

XS0T Moderate substance intoxication

Moderate substance intoxication is a state in which there are marked disturbances in psychophysiological functions and responses (e.g. motor coordination, attention and judgement) that vary by substance (see Table 6.15, p. 475), with substantial impairment on tasks that require these functions. There is some disturbance in level of consciousness.

XS25 Severe substance intoxication

Severe substance intoxication is a state in which there are obvious disturbances in psychophysiological functions and responses (e.g. motor coordination, attention and judgement) that vary by substance (see Table 6.15, p. 475), with marked disturbance in level of consciousness. There is severe impairment to the extent that the person may not be capable of self-care or self-protection, and may be unable to communicate or cooperate with assessment and intervention.

Note: extension codes are attached to the category to which they apply using an ampersand (&). For example, 6C40.3&XS0T is the code for alcohol intoxication, moderate and 6C41.3&XS5W is the code for cannabis intoxication, mild.

Additional clinical features for substance intoxication

- Psychoactive substances, whether of the same or a different pharmacological class, may interact such that they exacerbate or modify the features of intoxication. In cases of multiple psychoactive substance use in which more than one specific substance can be identified as a cause of the intoxication, it is recommended that the corresponding specific substance intoxication categories for each relevant substance should be assigned (e.g. 6C40.3 Alcohol intoxication and 6C41.3 Cannabis intoxication) rather than 6C4F.3 Intoxication due to multiple specified psychoactive substances.
- Substance intoxication may occur in the presence of medical conditions that cause impairment of levels of consciousness, cognition, perception, affect, behaviour or coordination, which should be diagnosed separately. Determination of the etiology of the disturbances in psychophysiological functions or responses may require longitudinal assessment.
- A diagnosis of intoxication due to unknown or unspecified psychoactive substances can be assigned if the substance consumed is initially unknown to the clinician. As more information becomes available (e.g. laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for intoxication.

Boundary with normality (threshold)

- Measurement of the presence or concentration of a substance in breath, blood, saliva, urine or other body fluids may be an important tool in the clinical management of substance intoxication. However, detection of a psychoactive substance in body fluids does not constitute a presumptive diagnosis of substance intoxication.

Course features

- The onset of substance intoxication varies according to the route of administration, the absorption of the substance and other pharmacokinetic factors. Generally, inhalation (smoking) and intravenous injecting routes lead to more rapid onset of intoxication, although oral ingestion may also lead to intoxication within minutes, depending on the substance.
- Substance intoxication is a transient condition, with the duration of intoxication depending on multiple factors, including the dose of the substance taken, the half-life and duration of action of the particular substance, and the formulation of the substance taken (e.g. for pharmaceutical preparations, whether a controlled-release drug has been taken). Intoxication may last from a few minutes to several days following the episode of use. The intensity of intoxication lessens with time after reaching a peak of absorption, and the effects eventually disappear in the absence of further use of the substance.

Developmental presentations

- Naive users – including adolescents – can show features of intoxication at lower levels of use, reflecting lower physical and learned tolerance.
- Older adults may have a lower tolerance than younger people to the effects of alcohol and other substances.

Culture-related features

- The degree and characteristics of intoxication displayed for a given amount of the substance vary considerably with circumstances, with beliefs and expectations about the effects of the substance, and with the cultural acceptability of displaying these effects. These factors result in cultural differences in the extent and manifestations of intoxication.

- There are also genetic differences in susceptibility to intoxication associated with certain ethnic groups. Cultural and ethnically linked genetic factors have been better documented for alcohol than for other substances.

Sex- and/or gender-related features

- The amount of substance and duration of use necessary to cause intoxication differs by sex, reflecting differences in body weight and composition.
- Behaviour while intoxicated may vary by gender, reflecting not only physiological differences but also cultural differences and role expectations.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with episode of harmful psychoactive substance use and harmful pattern of psychoactive substance use

In episode of harmful psychoactive substance use and harmful pattern of psychoactive substance use, consumption or administration of a substance results in damage to the person's physical or mental health (including a substance-induced mental disorder) or in behaviour leading to harm to the health of others. Recovery from substance intoxication is generally complete. Complications due to such effects of intoxication such as injury, the effects of hypoxia, the effects of prolonged hyperactivity or inactivity, or other tissue damage should be diagnosed as episode of harmful psychoactive substance use or harmful pattern of psychoactive substance use, as appropriate. If relevant at the time of the clinical encounter (e.g. in emergency settings), substance intoxication can be given as an associated diagnosis, with episode of harmful psychoactive substance use or harmful pattern of psychoactive substance use as the primary diagnosis.

Boundary with substance dependence

Episodic or continuous intoxication with a substance or substances is a typical feature of substance dependence. If all diagnostic requirements of both conditions are met for the same episode of care, substance dependence should be assigned as the primary diagnosis, with an associated diagnosis of substance intoxication (e.g. opioid dependence with opioid intoxication).

Boundary with substance withdrawal

Substance withdrawal occurs upon cessation or reduction of a substance in the context of physiological dependence or when a substance has been taken for a prolonged period or in large amounts. In contrast, the onset of substance intoxication occurs immediately or shortly after the consumption of a substance. Moreover, for a particular substance, the intoxication and withdrawal syndromes are typically quite distinct. See Table 6.15 (p. 475) for a description of the substance-specific features of substance intoxication and Table 6.16 (p. 484) for a description of the substance-specific features of substance withdrawal.

Boundary with substance-induced delirium

Delirium is characterized by disturbances in attention, orientation and awareness that develop within a short period of time, with symptoms that are transient and may fluctuate depending on the underlying etiology. Delirium often includes disturbance of behaviour and emotion, and may include impairment in multiple cognitive domains. Disturbance of the sleep-wake cycle may also be present. Delirium can be caused by intoxication or withdrawal from substances. When symptoms of delirium are attributable to substance intoxication, an associated diagnosis of substance-induced delirium should be assigned in addition to the diagnosis of substance intoxication. ***Note:*** substance-induced delirium is only applicable for some substances or substance classes (see Table 6.14, p. 454).

Boundary with other substance-induced mental disorders

Mental or behavioural symptoms that arise during substance intoxication should only be used as a basis for diagnosing a substance-induced mental disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of substance intoxication due to the specified substance (see Table 6.15, p. 475), and the symptoms are sufficiently severe to warrant specific clinical attention.

Boundary with other medical conditions

A variety of medical conditions may produce symptoms that are similar to those of substance intoxication (see Box 6.1 for examples). Some of these medical conditions are life-threatening, and require immediate intervention. Evidence of substance use (e.g. positive laboratory results) does not rule out the possibility of a comorbid medical condition. These alternative diagnoses must be considered in assessing substance intoxication. Certain medical conditions may also augment or prolong the duration of intoxication. Symptoms of intoxication that persist after they can no longer be reasonably attributed to the pharmacological effects of the substance may suggest the presence of another medical condition. If it is determined that substance intoxication is comorbid with a medical condition, both diagnoses should be assigned.

Boundary with overdose

When consumption or administration of psychoactive substances results in symptoms of overdose (e.g. coma, life-threatening cardiac or respiratory suppression), it is typically more appropriate to apply a diagnosis from the grouping of harmful effects of substances in Chapter 22 on injury, poisoning or certain other consequences of external causes rather than substance intoxication.

Table 6.15 sets out the disturbances in consciousness, cognition, perception, affect, behaviour or coordination that are most characteristic of intoxication with each class of psychoactive substances in the grouping of disorders due to substance use. These features are caused by the known pharmacological effects of the substance. Their intensity is closely related to the amount of the substance consumed, as well as the route of administration, interaction of the substance with other substances – including medications – and the duration of action of the substance. They are time-limited, and abate as the substance is cleared from the body.

Table 6.15. Common substance-specific features of substance intoxication

Substance	Common substance-specific features
Alcohol	Presenting features of alcohol intoxication may include impaired attention, inappropriate or aggressive behaviour, lability of mood and emotions, impaired judgement, poor coordination, unsteady gait, and slurred speech. At more severe levels of intoxication, stupor or coma may occur. **Additional features** • Alcohol intoxication may be associated with impaired social interaction. • Impaired coordination and judgement due to alcohol intoxication, even at low doses, may be sufficiently severe to affect the faculties necessary to operate motorized vehicles safely: alcohol intoxication is an important risk factor for road accidents. • The disinhibiting effects of alcohol are associated with an increased risk of attempted and completed suicides. • Higher blood levels of alcohol (e.g. >150 mg/dL) are associated with stupor and coma. Blood levels of alcohol above 250 mg/dL can cause respiratory depression, cardiac arrhythmias and death. • Stupor and coma are more likely to occur in individuals with low tolerance or comorbid medical conditions. • The more severe the intoxication, the greater the likelihood of subsequent amnesia for events that took place during the period of intoxication ("blackouts"). • Some symptoms of intoxication with other substances (e.g. sedatives, hypnotics or anxiolytics; opioids) may be similar to those of alcohol intoxication. Evidence of alcohol use (e.g. the smell of alcohol on the breath) does not rule out concomitant intoxication with other substances.
Cannabis or synthetic cannabinoids	Presenting features of cannabis intoxication or synthetic cannabinoid intoxication may include inappropriate euphoria, impaired attention, impaired judgement, perceptual alterations (such as the sensation of floating, altered perception of time), changes in sociability, increased appetite, anxiety, intensification of ordinary experiences, impaired short-term memory and sluggishness. Physical signs include conjunctival injection (red or bloodshot eyes), dry mouth and tachycardia. **Additional features** • The principal psychoactive cannabinoid is cannabis is THC. Disturbances in consciousness, cognition, perception, affect, behaviour or coordination typical of cannabis intoxication are primarily attributable to levels of THC, although various other cannabinoids are also present in cannabis preparations (e.g. dried leaves and buds, hashish, cannabis oil). • Synthetic cannabinoid intoxication may cause delirium or acute psychosis. • Regular intoxication with high potency cannabis or synthetic cannabinoids may be associated with increased long-term risk of psychosis. ***Note:*** medicinal cannabinoids such as cannabidiol and cannabinol – for example, those used as antispasmodics, anxiolytics or analgesics – typically have no or minimal intoxicating effects. However, standard laboratory testing for cannabinoids may not be able to differentiate among these different types of cannabinoids.

Table 6.15. contd

Substance	Common substance-specific features
Opioids	Presenting features of opioid intoxication may include somnolence, stupor, mood changes (e.g. euphoria followed by apathy and dysphoria), psychomotor retardation, impaired judgement, respiratory depression, slurred speech, and impairment of memory and attention. In severe intoxication, coma may ensue. A characteristic physical sign is pupillary constriction, but this sign may be absent when intoxication is due to synthetic opioids. **Additional features** • Severe opioid intoxication can lead to death due to excessive respiratory depression. Overdose is more likely to occur with higher-potency opioids (e.g. fentanyl), when the person has reduced tolerance (e.g. after detoxification) or when an individual who has developed tolerance uses the opioid in a novel environment. • Opioid intoxication shares certain features with alcohol intoxication and sedative, hypnotic or anxiolytic intoxication. Evidence of alcohol use (e.g. the smell of alcohol on the breath) does not rule out co-occurring opioid intoxication. • Where available, laboratory testing for substances that may be contributing to the intoxication or their metabolites may be necessary to identify the intoxicating substance. • Administration of an opioid antagonist (e.g. naloxone) may be used empirically in some settings (e.g. emergency settings) to differentiate opioid intoxication from intoxication with other substances.
Sedatives, hypnotics or anxiolytics	Presenting features of sedative, hypnotic or anxiolytic intoxication may include somnolence, impaired judgement, inappropriate behaviour (including sexual behaviour or aggression), slurred speech, impaired motor coordination, unsteady gait, mood changes, and impaired memory, attention and concentration. Nystagmus (repetitive, uncontrolled eye movements) is a common physical sign. In severe cases, stupor or coma may occur. **Additional features** • Impaired memory in sedative, hypnotic or anxiolytic intoxication is characterized by anterograde amnesia for the period of intoxication. • Sedatives, hypnotics or anxiolytics are commonly prescribed medications. They can cause intoxication even in therapeutic doses in older individuals and in those with medical comorbidities. • Some features of sedative, hypnotic or anxiolytic intoxication may be similar to those of opioid intoxication or alcohol intoxication. Evidence of alcohol use (e.g. the smell of alcohol on the breath) does not rule out concomitant sedative, hypnotic or anxiolytic intoxication. • Where available, laboratory testing for substances that may be contributing to the intoxication or their metabolites may be necessary to identify the intoxicating substance.
Cocaine	Presenting features of cocaine intoxication may include inappropriate euphoria, anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (sometimes of delusional intensity), auditory hallucinations, confusion and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations and chest pain may be experienced. Physical signs may include tachycardia, elevated blood pressure and pupillary dilatation. **Additional features** • In rare instances – usually in severe intoxication – cocaine use can result in seizures, muscle weakness, dyskinesia and dystonia, and myocardial infarction arising from coronary artery spasm or stroke arising from cerebral artery spasm.

Table 6.15. contd

Substance	Common substance-specific features
Stimulants, including amfetamines, methamfetamine and methcathinone	Presenting features of stimulant intoxication may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transient confusion and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesia and dystonia, and skin sores. **Additional features** • In rare instances – usually in severe intoxication – use of stimulants, including amfetamines, methamfetamine and methcathinone, can result in seizures.
Synthetic cathinones	Presenting features of synthetic cathinone intoxication may include anxiety, anger, impaired attention, hypervigilance, psychomotor agitation, paranoid ideation (possibly of delusional intensity), transient auditory hallucinations, transient confusion and changes in sociability. Perspiration or chills, nausea or vomiting, and palpitations may be experienced. Physical signs may include tachycardia, elevated blood pressure, pupillary dilatation, dyskinesia and dystonia, and skin sores. **Additional features** • In rare instances – usually in severe intoxication – use of synthetic cathinones can result in seizures.
Caffeine	Presenting features of caffeine intoxication may include restlessness, anxiety, excitement, insomnia, flushed face, tachycardia, diuresis, gastrointestinal disturbances, muscle twitching, psychomotor agitation, perspiration or chills, and nausea or vomiting. Cardiac arrythmias may occur. Disturbances typical of caffeine intoxication tend to occur at relatively high doses (e.g. >1 g per day). **Additional features** • Caffeine and related alkaloids (e.g. theobromine in tea) are present in a variety of foods (e.g. chocolate, kola nuts), beverages (e.g. sodas, guarana) and supplements (e.g. tablets, vitamins) that are consumed regularly and pervasively. • Very high doses of caffeine (e.g. >5 g) can result in respiratory distress or seizures, and can be fatal.
Hallucinogens	Presenting features of hallucinogen intoxication may include hallucinations, illusions, perceptual changes such as depersonalization, derealization, synaesthesias (blending of senses, such as a visual stimulus evoking a smell), anxiety, depressed or dysphoric mood, ideas of reference, paranoid ideation, impaired judgement, palpitations, sweating, blurred vision, tremors and lack of coordination. Physical signs may include tachycardia, elevated blood pressure and pupillary dilatation. **Additional features** • In rare instances, hallucinogen intoxication may increase suicidal behaviour.

Table 6.15. contd

Substance	Common substance-specific features
Nicotine	Presenting features of nicotine intoxication may include restlessness, psychomotor agitation, anxiety, cold sweats, headache, insomnia, palpitations, paraesthesias, nausea or vomiting, abdominal cramps, confusion, bizarre dreams, burning sensations in the mouth and salivation. **Additional features** • Nicotine intoxication occurs more commonly in people who have recently started smoking or using other forms of nicotine (e.g. electronic cigarettes or "vaping"), and have therefore not developed tolerance. It may also occur in people who receive nicotine therapeutically and take it in higher than recommended doses. • In rare instances, paranoid ideation, perceptual disturbances, convulsions or coma may occur.
Volatile inhalants	Presenting features of volatile inhalant intoxication may include euphoria, impaired judgement, aggression, somnolence, stupor or coma, dizziness, tremor, lack of coordination, slurred speech, unsteady gait, lethargy and apathy, psychomotor retardation and visual disturbance. Muscle weakness and diplopia may occur. **Additional features** • Intentional or unintentional exposure to a variety of volatile inhalant substances (e.g. glue, petrol, butane, paint) can cause the symptoms of volatile inhalant intoxication. • Intentional volatile inhalant intoxication typically involves "sniffing" or "huffing" the substances from closed containers, a practice that may lead to hypoxia, hypoxic brain damage and other long-lasting neurological sequelae. • Use of volatile inhalants may cause cardiac arrythmias, cardiac arrest and death. • Inhalants containing lead (e.g. some forms of petrol/gasoline) may cause confusion, irritability, coma and seizures. • Use of volatile inhalants is more common among adolescents and young adults due to the greater ease of access compared to other psychoactive substances.
MDMA or related drugs, including MDA	Presenting features of MDMA or related drug intoxication may include increased or inappropriate sexual interest and activity, anxiety, restlessness, agitation and sweating. **Additional features** • In rare instances – usually in severe intoxication – use of MDMA or related drugs, including MDA, can result in dystonia and seizures. Sudden death is a rare but recognized complication.
Dissociative drugs, including ketamine and PCP	Presenting features of dissociative drug intoxication may include aggression, impulsivity, unpredictable behaviour, anxiety, psychomotor agitation, impaired judgement, numbness or diminished responsiveness to pain, slurred speech and dystonia. Physical signs include nystagmus (repetitive, uncontrolled eye movements), tachycardia, elevated blood pressure, numbness, ataxia, dysarthria and muscle rigidity. **Additional features** • In rare instances, use of dissociative drugs, including ketamine and PCP, can result in seizures. • Laboratory tests to quantify PCP levels are only weakly correlated with disturbances in consciousness, cognition, perception, affect, behaviour or coordination.

Substance withdrawal

Available categories by substance class

6C40.4	Alcohol withdrawal
6C41.4	Cannabis withdrawal
6C42.4	Synthetic cannabinoid withdrawal
6C43.4	Opioid withdrawal
6C44.4	Sedative, hypnotic or anxiolytic withdrawal
6C45.4	Cocaine withdrawal
6C46.4	Stimulant withdrawal, including amfetamines, methamfetamine and methcathinone
6C47.4	Synthetic cathinone withdrawal
6C48.3	Caffeine withdrawal
6C4A.4	Nicotine withdrawal
6C4B.4	Volatile inhalant withdrawal
6C4C.4	MDMA or related drug withdrawal, including MDA
6C4E.4	Other specified psychoactive substance withdrawal
6C4F.4	Multiple specified psychoactive substances withdrawal
6C4G.4	Withdrawal due to unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by a clinically significant cluster of symptoms, behaviours and/or physiological features that occurs upon cessation or reduction in the use of a substance in individuals who have developed dependence on that substance, or have used the substance for a prolonged period or in large amounts. ***Note:*** substance withdrawal can occur when prescribed psychoactive medications (e.g. opioids, anxiolytics, stimulants) have been used in standard therapeutic doses.
- The specific features of substance withdrawal depend on the pharmacological properties of the specified substance (see Table 6.16, p. 484), and are consistent with those recognized as occurring upon cessation or reduction of the particular substance or other members of the same pharmacological group of substances. The symptoms also vary in degree of severity and duration, depending on the substance and the amount and pattern of prior use.
- The symptoms are not better accounted for by another medical condition or another mental disorder.

Note: substance withdrawal is only applicable for some substances or substance classes (see the list above and Table 6.13, p. 450). Table 6.16 (p. 484) lists the most common symptoms, behaviours and physiological features for each substance class.

Specifiers for clinical presentation of substance withdrawal

Because of clinically important variation in their withdrawal syndromes, the following specifiers can be applied to alcohol withdrawal (6C40.4) and sedatives, hypnotics or anxiolytics withdrawal (6C44.4), as well as the withdrawal syndrome for other specified (6C4E.4), multiple (6C4F.4) and unspecified (6C4G.4) psychoactive substance categories. The *x* below corresponds to the fourth-character code indicating the substance class (0 for alcohol, 1 for cannabis and so on).

6C4*x*.40 Substance withdrawal, uncomplicated

All diagnostic requirements for substance withdrawal are met, and the withdrawal state is not accompanied by perceptual disturbances or seizures.

6C4*x*.41 Substance withdrawal, with perceptual disturbances

All diagnostic requirements for substance withdrawal are met, and the withdrawal state is accompanied by perceptual disturbances (e.g. visual or tactile hallucinations or illusions) with intact reality testing. There is no evidence of confusion, and other diagnostic requirements for delirium are not met. The withdrawal state is not accompanied by seizures.

6C4*x*.42 Substance withdrawal, with seizures

All diagnostic requirements for substance withdrawal are met, and the withdrawal state is accompanied by seizures (i.e. generalized tonic-clonic seizures) but not by perceptual disturbances.

6C4*x*.43 Substance withdrawal, with perceptual disturbances and seizures

All diagnostic requirements for substance withdrawal are met, and the withdrawal state is accompanied by both seizures (i.e. generalized tonic-clonic seizures) and perceptual disturbances (e.g. visual or tactile hallucinations or illusions) with intact reality testing. Diagnostic requirements for delirium are not met.

6C4*x*.4Z Substance withdrawal, unspecified

Additional clinical features for substance withdrawal

- For some substances, characteristic features of substance withdrawal are opposite to the acute pharmacological effects of that substance (see Table 6.15, p. 475, and Table 6.16, p. 484).
- Substance withdrawal symptoms become more severe with repeated episodes of withdrawal (termed "kindling"), with ageing, or in the presence of comorbid medical conditions.
- A diagnosis of substance withdrawal due to unknown or unspecified psychoactive substances can be assigned if the substance consumed is initially unknown. As more information becomes available (e.g. laboratory results, report from a collateral informant) the diagnosis should be changed to indicate the substance responsible for the withdrawal symptoms.

Boundary with normality (threshold)

- Substance withdrawal should only be diagnosed when symptoms are consistent with those recognized as occurring upon cessation or reduction in use of the particular substance or pharmacologically related group of substances (see Table 6.16, p. 484). Recent cessation or reduction of use and the presence of various nonspecific transient symptoms is not sufficient to make the diagnosis of substance withdrawal.
- Withdrawal symptoms should be differentiated from the transient physiological aftereffects of intoxication ("hangover effect"). For example, if low mood and reduction in energy are reported following use of alcohol; sedatives, hypnotics or anxiolytics; stimulants; or MDMA or related drugs, and other characteristic features of substance withdrawal are not present, a diagnosis of substance withdrawal should not be assigned. The presence of a set of associated symptoms specific to different classes of psychoactive substances (see Table 6.16, p. 484) – as well as the frequency, amount and duration of its use and presence of substance dependence – should be considered in distinguishing substance withdrawal from a "hangover effect".
- Some individuals who have previously had substance dependence may experience symptoms similar to those of substance withdrawal months after the last use of the substance, particularly when the individual encounters stimuli (e.g. drug paraphernalia) and contexts (e.g. location where use was frequent) previously associated with past substance use. These symptoms are more transient than those observed during substance withdrawal, and occur exclusively when in contact with associated stimuli and contexts. A diagnosis of substance withdrawal should not be assigned under these circumstances.

Course features

- Substance withdrawal is time-limited. Factors that influence the features and time course of substance withdrawal include the severity of substance dependence (if present); the dose, frequency of use and duration of use of the substance prior to cessation or reduction of that use; the half-life and duration of action of the substance; and the presence of comorbid medical conditions (e.g. metabolic disturbances).

Culture-related features

- Symptoms of withdrawal depend largely on the psychotropic characteristics of the substance.
- However, specific cultures may emphasize certain symptoms of withdrawal over others, making it more difficult to conduct a differential diagnosis. In addition, vernacular terms for withdrawal vary greatly.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with substance dependence

Depending on the substance, many individuals with substance dependence develop substance withdrawal upon cessation or reduction in the amount of the substance. In such cases, both substance dependence and substance withdrawal should be diagnosed. However, substance withdrawal can be diagnosed in the absence of a diagnosis of substance dependence – for example, in response to cessation of medically appropriate treatment with opioid analgesics that is not accompanied by the other essential features of substance dependence.

Boundary with substance intoxication

The onset of substance intoxication occurs immediately or shortly after the consumption of a substance. In contrast, substance withdrawal occurs upon cessation or reduction in the amount of a substance in the context of substance dependence, or when a substance has been taken for a prolonged period or in large amounts. For a particular substance, the intoxication and withdrawal syndromes are typically distinct. See Table 6.15 (p. 475) for a description of the substance-specific features of substance intoxication and Table 6.16 (p. 484) for a description of the substance-specific features of substance withdrawal.

Boundary with substance-induced delirium

Delirium is characterized by disturbances in attention, orientation and awareness that develop within a short period of time, with symptoms that are transient and may fluctuate depending

on the underlying etiology. Delirium often includes disturbance of behaviour and emotion, and may include impairment in multiple cognitive domains. Disturbance of the sleep-wake cycle may also be present. Delirium may occur as an aspect of substance withdrawal, particularly during later stages of withdrawal. In such cases, diagnoses of both substance withdrawal and substance-induced delirium should be assigned. ***Note:*** substance-induced delirium is only applicable for some substances or substance classes (see Table 6.14, p. 454).

Boundary with other substance-induced mental disorders

Mental or behavioural symptoms that arise during substance withdrawal should only be used as a basis for diagnosing a substance-induced mental disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of the substance withdrawal due to the specified substance (see Table 6.16, p. 484), and the symptoms are sufficiently severe to warrant specific clinical attention. In such cases, if the withdrawal syndrome is ongoing, diagnoses of both substance withdrawal and a substance-induced mental disorder may be assigned.

Boundary with other mental disorders

Various symptoms associated with substance withdrawal overlap with those that are characteristic of other mental disorders (e.g. depressive and anxiety symptoms). Symptoms of substance withdrawal occur in specific temporal relationship to the cessation of use of a specific substance, and diminish with the passage of time. Evidence supporting a mental disorder diagnosis would include the symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more, depending on the substance), or other evidence of a pre-existing mental disorder (e.g. a history of prior episodes not associated with substance use).

Boundary with other medical conditions

It may be difficult to distinguish between various symptoms associated with substance withdrawal (e.g. nausea, retching or vomiting, seizures, abdominal cramps, diarrhoea, perspiration, postural hypotension, decreased or increased heart rate, cough, sleep disruption) and those that are characteristic of other medical conditions. Symptoms of substance withdrawal occur in specific temporal relationship to the cessation of use of a specific substance and diminish with the passage of time.

Boundary with fetus or newborn affected by maternal use of tobacco, alcohol, or other drugs of addiction

Chapter 19 on certain conditions arising during the perinatal period contains a category of fetus or newborn affected by maternal use of tobacco, alcohol and other drugs. A neonate exhibiting signs of substance withdrawal related to a specific substance may also be assigned the appropriate substance withdrawal diagnosis in order to guide treatment together with appropriate diagnosis from Chapter 19.

Substance withdrawal is a cluster of symptoms, behaviours and physiological features, varying in degree of severity and duration, that occur upon cessation or reduction of use of a psychoactive substance in individuals who have developed dependence on that substance, or who have taken the substance for a prolonged period or in large amounts. The diagnosis of substance withdrawal

is applicable only to certain substances and substance groups (see Table 6.13, p. 450). Specific presenting features that may occur as a part of substance withdrawal for each applicable class of psychoactive substances in the grouping of disorders due to substance use are listed in Table 6.16.

Table 6.16. Common substance-specific features of substance withdrawal

Substance	Substance-specific features of withdrawal
Alcohol	Presenting features of alcohol withdrawal may include autonomic hyperactivity (e.g. tachycardia, hypertension, perspiration), increased hand tremor, nausea, retching or vomiting, insomnia, anxiety, psychomotor agitation, depressed or dysphoric mood, transient visual, tactile or auditory illusions or hallucinations, and distractibility. Less commonly, alcohol withdrawal is complicated by seizures. **Additional features** • Onset of alcohol withdrawal typically occurs within 6–12 hours after last use, as blood alcohol concentrations decline. Symptoms vary in type, severity, onset and duration, according to the duration and intensity of alcohol use prior to cessation or reduction of use. • Features of mild or moderate withdrawal typically last for 3–7 days after cessation of alcohol use, and include autonomic hyperactivity, increased hand tremor, anxiety, insomnia, nausea, vomiting and headache. Features of moderate withdrawal may also include transient visual, tactile or auditory illusions or hallucinations, distractibility and psychomotor agitation. • In 1–3% of cases, alcohol withdrawal is complicated by seizures of a tonic-clonic type. When seizures occur, they are usually single seizures with onset within 6–48 hours after last use. Evidence of a premorbid seizure disorder, other intracranial pathology or co-occurring use of other substances does not preclude a presumptive alcohol withdrawal diagnosis. • Approximately 2% of cases of alcohol withdrawal progress to a very severe syndrome sometimes referred to as "delirium tremens" (or DTs), characterized by confusion and disorientation, delusions and prolonged visual, tactile or auditory hallucinations. When delirium is present, a separate diagnosis of 6C40.5 Alcohol-induced delirium should also be assigned. The presence of seizures during withdrawal represents a risk factor for development of delirium. If unrecognized or untreated, delirium during alcohol withdrawal is associated with substantially increased mortality compared to alcohol withdrawal without co-occurring delirium. • Some symptoms associated with alcohol withdrawal – such as autonomic hyperactivity, anxiety and insomnia – can recur or persist for several months after abstinence, particularly when the person is exposed to alcohol-associated cues (a conditioned withdrawal state). The presence of such persisting symptoms is not sufficient to meet diagnostic requirements for alcohol withdrawal.
Cannabis	Presenting features of cannabis withdrawal may include irritability, anger or aggressive behaviour, shakiness, insomnia, restlessness, anxiety, depressed or dysphoric mood, decreased appetite and weight loss, headache, sweating or chills, abdominal cramps and muscle aches. **Additional features** • The occurrence, severity and duration of cannabis withdrawal vary according to the type and potency of the cannabis preparation, as well as the amount, frequency and duration of use before cessation or reduction of use. • Onset of cannabis withdrawal typically occurs at some point between 12 hours and 3 days after cessation or reduction of use. Symptom severity typically peaks at 4–7 days and may last for 1–3 weeks after cessation of use. However, cannabis withdrawal may also be briefer, in some cases lasting only a few days. • When cannabis withdrawal occurs in the context of a co-occurring mental disorder, the features of the other disorder (e.g. fluctuation of mood) may be exacerbated.

Table 6.16. contd

Substance	Substance-specific features of withdrawal
Synthetic cannabinoids	Presenting features of synthetic cannabinoid withdrawal may include irritability, anger, aggression, shakiness, insomnia and disturbing dreams, restlessness, anxiety, depressed or dysphoric mood and appetite disturbance. In the early phase, synthetic cannabinoid withdrawal may be accompanied by residual features of intoxication from the drug, such as paranoid ideation and auditory and visual hallucinations. **Additional features** • The occurrence, severity and duration of synthetic cannabinoid withdrawal vary according to the type and potency of the synthetic cannabinoid used, as well as the amount, frequency and duration of use before cessation or reduction of use. • Synthetic cannabinoid withdrawal typically lasts for 1–3 weeks after cessation of use.
Opioids	Presenting features of opioid withdrawal may include depressed or dysphoric mood, craving for an opioid, anxiety, nausea or vomiting, abdominal cramps, muscle aches, yawning, perspiration, hot and cold flushes, hypersomnia (typically in the initial phase) or insomnia, diarrhoea, piloerection and pupillary dilation. **Additional features** • The severity and time course of opioid withdrawal is influenced by many factors that include the type of opioid taken, its half-life and duration of action, the amount, frequency and duration of opioid use before cessation or reduction of use, prior experience of opioid withdrawal, and expectations of the severity of the syndrome. • Opioid withdrawal from short-acting opioids such as injected heroin or morphine typically begins within 4–12 hours of cessation of use and lasts for 4–10 days. • Opioid withdrawal from longer-acting opioids such as codeine, oxycodone and similar pharmaceutical agents may not be evident for 2–4 days and may last for 1–2 weeks. • The withdrawal state from long-acting drugs such as methadone may persist for up to 2 months after cessation of use. • Opioid withdrawal occurs in phases. The early phase typically includes lacrimation, rhinorrhoea and yawning. This is followed by hot and cold flashes, muscle aching and abdominal cramps, nausea and vomiting and diarrhoea; piloerection and pupillary dilatation may also occur. The later phase is dominated by craving for opioids. • Recurrence or worsening of pain may occur if the opioid was used to manage chronic pain. • Serious medical complications of opioid withdrawal are rare. Fluid depletion may occasionally lead to renal impairment. Death during opioid withdrawal is very uncommon.

Table 6.16. contd

Substance	Substance-specific features of withdrawal
Sedatives, hypnotics or anxiolytics	Presenting features of sedative, hypnotic or anxiolytic withdrawal may include anxiety, psychomotor agitation, insomnia, increased hand tremor, nausea or vomiting, and transient visual, tactile or auditory illusions or hallucinations. There may be signs of autonomic hyperactivity (e.g. tachycardia, hypertension, perspiration) or postural hypotension. The withdrawal state may be complicated by seizures. **Additional features** • The severity and time course of sedative, hypnotic or anxiolytic withdrawal is related to the particular substance taken, its half-life and duration of action, and the amount, frequency and duration of use before cessation or reduction of use. • The withdrawal state associated with short-acting drugs typically has its onset within 12–24 hours after cessation of use and has a course of up to 14 days. Withdrawal onset may be delayed by 3–5 days with longer-acting drugs and may persist for several weeks. • Sedative, hypnotic or anxiolytic withdrawal may be complicated by seizures, which are of a tonic-clonic type and may be single or multiple. • Sedative, hypnotic or anxiolytic withdrawal, especially when untreated, may progress to a very severe form of delirium, characterized by confusion and disorientation, delusions, and more prolonged visual, tactile or auditory hallucinations. In such cases, a separate diagnosis of 6C44.5 Sedative, hypnotic or anxiolytic-induced delirium should also be assigned. • Medical sequelae of complicated withdrawal include status epilepticus, respiratory compromise and renal failure. • Some features of sedative, hypnotic or anxiolytic withdrawal – such as anxiety, transient illusions or hallucinations, and derealization – may persist for several months after cessation of use.
Cocaine	Presenting features of cocaine withdrawal may include depressed or dysphoric mood, irritability, fatigue, psychomotor agitation or retardation, vivid unpleasant dreams, insomnia or hypersomnia, increased appetite, anxiety and craving for cocaine. **Additional features** • Initial symptoms of cocaine withdrawal include a dysphoric and low energy state manifested in depressed or dysphoric mood, irritability, fatigue, inertia and hypersomnia. This typically occurs within 6–24 hours of cessation of cocaine use. • The withdrawal state may last up to 7 days. Craving for cocaine is prominent in the later stages. • Suicidal ideation may occur, especially when dysphoric mood is marked. • At the onset of cocaine withdrawal there may be features that persist from the intoxicating effects of cocaine, such as hyperactivity, paranoid ideation and auditory hallucinations.
Stimulants, including amfetamines, methamfetamine and methcathinone	Presenting features of stimulant withdrawal may include depressed or dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for amfetamine and related stimulants. **Additional features** • Stimulant withdrawal typically occurs within 24 hours to 4 days of cessation of stimulant use, and is characterized by a dysphoric and low energy state manifested in depressed or dysphoric mood, irritability, fatigue, inertia and hypersomnia. • The severity and duration of the withdrawal state is widely variable based on the type of stimulant taken and the amount, frequency and duration of such use prior to its cessation. • In the first phase of stimulant withdrawal, which typically lasts for 7–14 days, low mood, lethargy and hypersomnia predominate. After this phase, irritability and craving for stimulants are prominent and may persist for 6–8 weeks. • At the onset of stimulant withdrawal there may be features that persist from the intoxicating effects of the stimulant, such as hyperactivity, paranoid ideation and auditory hallucinations.

Table 6.16. contd

Substance	Substance-specific features of withdrawal
Synthetic cathinones	Presenting features of synthetic cathinone withdrawal may include depressed or dysphoric mood, irritability, fatigue, insomnia or (more commonly) hypersomnia, vivid and unpleasant dreams, increased appetite, psychomotor agitation or retardation, and craving for stimulants, including synthetic cathinones.
Caffeine	Presenting features of caffeine withdrawal may include headache, marked fatigue or drowsiness, irritability, depressed or dysphoric mood, nausea or vomiting, and difficulty concentrating. **Additional features:** • The severity and duration of caffeine withdrawal is related to the amount, frequency and duration of caffeine use prior to cessation of use. • Onset of caffeine withdrawal is typically 12–48 hours after the last use and may last up to 7 days.
Nicotine	Presenting features of nicotine withdrawal may include depressed or dysphoric mood, insomnia, irritability, anger, anxiety, difficulty concentrating, restlessness, bradycardia, increased appetite, and craving for tobacco or other nicotine-containing products. Other physical symptoms may include increased cough and mouth ulceration. **Additional features:** • The severity and duration of nicotine withdrawal is variable, related to the amount, frequency and duration of tobacco smoked (or otherwise consumed) or of nicotine products taken prior to cessation of use. • Onset of nicotine withdrawal is typically 6–24 hours after cessation or reduction of use. Psychological and physiological features typically last up to 10 days. Physical features such as increased cough and mouth ulceration may persist for 2–3 weeks. • Craving for tobacco (or other nicotine-containing products) is prominent throughout the duration of nicotine withdrawal.
Volatile inhalants	Presenting features of volatile inhalant withdrawal may include insomnia, anxiety, irritability, depressed or dysphoric mood, shakiness, perspiration, nausea and transient illusions. **Additional features:** • The severity and duration of volatile inhalant withdrawal is related to the type of inhalant used and to the amount, frequency and duration of use of the specific inhalant. • Volatile inhalant withdrawal may be accompanied by persisting features of volatile inhalant intoxication or its medical complications, such as encephalopathy – especially when the inhalant used is lead-containing petrol/gasoline.
MDMA or related drugs, including MDA	Presenting features of MDMA or related drug withdrawal may include fatigue, lethargy, hypersomnia or insomnia, depressed mood, anxiety, irritability, craving, difficulty in concentrating and appetite disturbance. **Additional features** • The above information primarily concerns withdrawal from MDMA. There is insufficient information on the features and course of the withdrawal state from drugs related to MDMA, including MDA, to fully characterize the associated withdrawal states. • MDMA withdrawal is uncommon, reflecting the comparative rarity of MDMA dependence. • Onset of MDMA withdrawal typically occurs within 12–24 hours after last use, as blood concentrations decline. The features vary in type, severity, onset and duration according to the amount, frequency and duration of MDMA use prior to cessation of use. • The duration of MDMA withdrawal may be up to 10 days. Craving for MDMA may be prominent during the later stages.

Substance-induced mental disorders

Substance-induced mental disorders are characterized by psychological, cognitive or behavioural symptoms that develop during or soon after psychoactive substance intoxication or withdrawal, or use or discontinuation of a psychoactive medication. The duration or severity of the symptoms is substantially in excess of the characteristic syndrome of substance intoxication or substance withdrawal due to the specified substance.

Substance-induced mental disorders include:

Substance-induced delirium
Substance-induced psychotic disorder

- with hallucinations
- with delusions
- with mixed psychotic symptoms

Substance-induced mood disorder

- with depressive symptoms
- with manic symptoms
- with mixed depressive and manic symptoms

Substance-induced anxiety disorder
Substance-induced obsessive-compulsive or related disorder
Substance-induced impulse control disorder.

Specific types of substance-induced mental disorders are only applicable for some substance classes, which are listed along with corresponding codes in the sections on specific substance-induced mental disorders below, as well as in Table 6.14 (p. 454). Specific substance-induced mental disorders may characteristically have their onset during or soon after substance intoxication and/or substance withdrawal for specific substances or substance classes.

When making a diagnosis of substance-induced mental disorder, an additional diagnosis indicating the related pattern of substance use should also be assigned. These include episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use and substance dependence. A diagnosis of substance intoxication or substance withdrawal may also be assigned if applicable.

Additional categories of substance-induced disorders are included in other groupings of this chapter on mental, behavioural and neurodevelopmental disorders, and CDDR are provided in the corresponding sections. These categories are cross-listed in this section for reference, and include:

6A41	Catatonia induced by substances or medications (p. 204).
6D70.1	Delirium due to psychoactive substances, including medications (p. 606).
6D72.1	Amnestic disorder due to psychoactive substances, including medications (p. 616).
6D84	Dementia due to psychoactive substances, including medications (p. 626).

Essential features for each substance-induced mental disorder category are provided below, as are any specifiers corresponding to specific disorders. Other CDDR elements – additional clinical features, boundary with normality (threshold) and boundaries with other disorders and conditions (differential diagnosis) – apply to all substance-induced mental disorder categories and are provided at the end of this section.

Substance-induced delirium

Available categories by substance class

6C40.5	Alcohol-induced delirium
6C41.5	Cannabis-induced delirium
6C42.5	Synthetic cannabinoid-induced delirium
6C43.5	Opioid-induced delirium
6C44.5	Sedative, hypnotic or anxiolytic-induced delirium
6C45.5	Cocaine-induced delirium
6C46.5	Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone
6C47.5	Synthetic cathinone-induced delirium
6C49.4	Hallucinogen-induced delirium
6C4B.5	Volatile inhalant-induced delirium
6C4C.5	MDMA or related drug-induced delirium, including MDA
6C4D.4	Dissociative drug-induced delirium, including ketamine and PCP
6C4E.5	Delirium induced by other specified psychoactive substances, including medications
6C4F.5	Delirium induced by multiple specified psychoactive substances, including medications
6C4G.5	Delirium induced by unknown or unspecified psychoactive substances

CDDR for substance-induced delirium are provided as part of the grouping of neurocognitive disorders (delirium due to psychoactive substances, including medications, p. 606).

Substance-induced psychotic disorders

Available categories by substance class

6C40.6	Alcohol-induced psychotic disorder
6C41.6	Cannabis-induced psychotic disorder
6C42.6	Synthetic cannabinoid-induced psychotic disorder
6C43.6	Opioid-induced psychotic disorder
6C44.6	Sedative, hypnotic or anxiolytic-induced psychotic disorder
6C45.6	Cocaine-induced psychotic disorder
6C46.6	Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone
6C47.6	Synthetic cathinone-induced psychotic disorder
6C49.5	Hallucinogen-induced psychotic disorder
6C4B.6	Volatile inhalant-induced psychotic disorder
6C4C.6	MDMA or related drug-induced psychotic disorder, including MDA
6C4D.5	Dissociative drug-induced psychotic disorder, including ketamine and PCP
6C4E.6	Psychotic disorder induced by other specified psychoactive substance
6C4F.6	Psychotic disorder induced by multiple specified psychoactive substances
6C4G.6	Psychotic disorder induced by unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by psychotic symptoms (e.g. delusions, hallucinations or disorganized thinking or behaviour) that develop during or soon after intoxication with or withdrawal from a specified substance, or use or discontinuation of a psychoactive medication.
- The intensity or duration of the psychotic symptoms is substantially in excess of psychotic-like disturbances of perception, cognition or behaviour that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing psychotic symptoms (see the list above and Table 6.14, p. 454).
- The symptoms are not better accounted for by another mental disorder such as schizophrenia or a mood disorder with psychotic symptoms. Evidence supporting a diagnosis of another mental disorder would include psychotic symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance, or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with psychotic symptoms (e.g. a history of prior episodes not associated with substance use).
- The symptoms are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for substance-induced psychotic symptoms

An additional specifier can be added to denote the presence of hallucinations, delusions, or mixed psychotic symptoms for alcohol-induced psychotic disorder (6C40.6), cocaine-induced psychotic disorder (6C45.6), stimulant-induced psychotic disorder, including amfetamines, methamfetamine or methcathinone (6C46.6), and synthetic cathinone-induced psychotic disorder (6C47.6). The x below corresponds to the fourth-character code indicating the substance class (0 for alcohol, 1 for cannabis and so on) (see the list above and Table 6.14, p. 454).

6C4*x*.60 Substance-induced psychotic disorder with hallucinations

- All diagnostic requirements for substance-induced psychotic disorder are met.
- The presentation is characterized by hallucinations that are judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Neither delusions nor other psychotic symptoms are present.
- The symptoms do not occur exclusively during hypnogogic or hypnopompic states.

6C4x.61 Substance-induced psychotic disorder with delusions

- All diagnostic requirements for substance-induced psychotic disorder are met.
- The presentation is characterized by delusions that are judged to be the direct consequence of use of or withdrawal from a specified substance or medication.
- Neither hallucinations nor other psychotic symptoms are present.

6C4*x*.62 Substance-induced psychotic disorder with mixed psychotic symptoms

- All diagnostic requirements for substance-induced psychotic disorder are met.
- The presentation is characterized by multiple psychotic symptoms, primarily hallucinations and delusions, when these are judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.

6C4*x*.6Z Substance-induced psychotic disorder, unspecified

Substance-induced mood disorders

Available categories by substance class

6C40.70	Alcohol-induced mood disorder
6C41.70	Cannabis-induced mood disorder
6C42.70	Synthetic cannabinoid-induced mood disorder
6C43.70	Opioid-induced mood disorder
6C44.70	Sedative, hypnotic or anxiolytic-induced mood disorder
6C45.70	Cocaine-induced mood disorder
6C46.70	Stimulant-induced mood disorder, including amfetamines, methamfetamine and methcathinone
6C47.70	Synthetic cathinone-induced mood disorder
6C49.60	Hallucinogen-induced mood disorder
6C4B.70	Volatile inhalant-induced mood disorder
6C4C.70	MDMA or related drug-induced mood disorder, including MDA
6C4D.60	Dissociative drug-induced mood disorder, including ketamine and PCP
6C4E.70	Mood disorder induced by other specified psychoactive substance
6C4F.70	Mood disorder induced by multiple specified psychoactive substances
6C4G.70	Mood disorder induced by unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by mood symptoms (e.g. depressed or elevated mood, decreased engagement in pleasurable activities, increased or decreased energy levels) that

develop during or soon after intoxication, with or withdrawal from a specified substance or use or discontinuation of a psychoactive medication.

- The intensity or duration of the mood symptoms is substantially in excess of mood symptoms that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing mood symptoms (see the list above and Table 6.14, p. 454).
- The symptoms are not better accounted for by another mental disorder such as a depressive disorder, a bipolar disorder, or schizophrenia or another primary psychotic disorder. Evidence supporting a diagnosis of another mental disorder would include mood symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with mood symptoms (e.g. a history of prior episodes not associated with substance use).
- The symptoms are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Specifiers for substance-induced mood symptoms

An additional specifier can be added to denote the presence of depressive symptoms in the absence of manic symptoms, manic symptoms in the absence of depressive symptoms, or mixed manic and depressive symptoms. The *x* below corresponds to the fourth-character code indicating the substance class (0 for alcohol, 1 for cannabis and so on). The *y* represents the character that correspond to substance-induced mood disorder for that class of substances (see the list above and Table 6.14, p. 454). For example, 6C40.700 is alcohol-induced mood disorder with depressive symptoms and 6C4D.602 is dissociative drug-induced mood disorder with mixed depressive and manic symptoms.

6C4x.y00 Substance-induced mood disorder with depressive symptoms

- All diagnostic requirements for substance-induced mood disorder are met.
- The presentation is characterized by depressive symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Manic symptoms are not present.

6C4x.y01 Substance-induced mood disorder with manic symptoms

- All diagnostic requirements for substance-induced mood disorder are met.
- The presentation is characterized by manic symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.
- Depressive symptoms are not present.

6C4*x*.*y*02 Substance-induced mood disorder with mixed depressive and manic symptoms

- All diagnostic requirements for substance-induced mood disorder are met.
- The presentation is characterized by both depressive and manic symptoms judged to be the direct consequence of the use of or withdrawal from a specified substance or medication.

6C4*x*.*y*0Z Substance-induced mood disorder, unspecified

Substance-induced anxiety disorders

Available categories by substance class

6C40.71	Alcohol-induced anxiety disorder
6C41.71	Cannabis-induced anxiety disorder
6C42.71	Synthetic cannabinoid-induced anxiety disorder
6C43.71	Opioid-induced anxiety disorder
6C44.71	Sedative, hypnotic or anxiolytic-induced anxiety disorder
6C45.71	Cocaine-induced anxiety disorder
6C46.71	Stimulant-induced anxiety disorder, including amfetamines, methamfetamine and methcathinone
6C47.71	Synthetic cathinone-induced anxiety disorder
6C48.40	Caffeine-induced anxiety disorder
6C49.61	Hallucinogen-induced anxiety disorder
6C4B.71	Volatile inhalant-induced anxiety disorder
6C4C.71	MDMA or related drug-induced anxiety disorder, including MDA
6C4D.61	Dissociative-induced anxiety disorder, including ketamine and PCP
6C4E.71	Anxiety disorder induced by other specified psychoactive substance
6C4F.71	Anxiety disorder induced by multiple specified psychoactive substances
6C4G.71	Anxiety disorder induced by unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by anxiety symptoms (e.g. apprehension or worry, fear, physiological symptoms of excessive autonomic arousal, panic attacks, avoidance behaviour) that develop during or soon after intoxication with or withdrawal from a specified substance, or use or discontinuation of a psychoactive medication.
- The intensity or duration of the anxiety symptoms is substantially in excess of anxiety symptoms that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing anxiety symptoms (see the list above and Table 6.14, p. 454).
- The symptoms are not better accounted for by another mental disorder such as an anxiety or fear-related disorder, a depressive disorder with prominent anxiety symptoms, or post-traumatic stress disorder. Evidence supporting a diagnosis of another mental disorder

would include anxiety symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder with anxiety symptoms (e.g. a history of prior episodes not associated with substance use).

- The symptoms are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Substance-induced obsessive-compulsive and related disorders

Available categories by substance class

6C45.72	Cocaine-induced obsessive-compulsive or related disorder
6C46.72	Stimulant-induced obsessive-compulsive or related disorder, including amfetamines, methamfetamine and methcathinone
6C47.72	Synthetic cathinone-induced obsessive-compulsive or related disorder
6C4E.72	Obsessive-compulsive or related disorder induced by other specified psychoactive substance
6C4F.72	Obsessive-compulsive or related disorder induced by multiple specified psychoactive substances
6C4G.72	Obsessive-compulsive or related disorder induced by unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by symptoms that share primary clinical features with obsessive-compulsive and related disorders (e.g. obsessions, intrusive thoughts and preoccupations, compulsions, recurrent and habitual actions directed at the integument).
- The obsessive-compulsive or related symptoms develop during or soon after intoxication with or withdrawal from a specified substance, or use or discontinuation of a psychoactive medication.
- The intensity or duration of the repetitive preoccupations and behaviours is substantially in excess of analogous disturbances that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing obsessive-compulsive or related symptoms (see the list above and Table 6.14, p. 454).
- The symptoms and behaviours are not better accounted for by another mental disorder – in particular an obsessive-compulsive or related disorder. Evidence supporting a diagnosis of another mental disorder would include obsessive-compulsive or related symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or

more depending on the specific substance), or other evidence of a pre-existing mental disorder with obsessive-compulsive or related symptoms (e.g. a history of prior episodes not associated with substance use).

- The symptoms and behaviours are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Substance-induced impulse control disorders

Available categories by substance class

6C45.73	Cocaine-induced impulse control disorder
6C46.73	Stimulant-induced impulse control disorder, including amfetamines, methamfetamine and methcathinone
6C47.73	Synthetic cathinone-induced impulse control disorder
6C4E.73	Impulse control disorder induced by other specified psychoactive substance
6C4F.73	Impulse control disorder induced by multiple specified psychoactive substances
6C4G.73	Impulse control disorder induced by unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by persistently repeated behaviours in which there is recurrent failure to resist an impulse, drive or urge to perform an act that is rewarding to the person – at least in the short term – despite longer-term harm either to the individual or to others (e.g. fire setting or stealing without apparent motive, repetitive sexual behaviour, aggressive outbursts), or by behaviours similar to those seen in disorders due to addictive behaviours (i.e. excessive gambling or gaming).
- The disturbance in impulse control develops during or soon after intoxication with or withdrawal from a specified substance, or use or discontinuation of a psychoactive medication.
- The intensity or duration of the disturbance in impulse control is substantially in excess of impulse control disturbances that are characteristic of intoxication or withdrawal due to the specified substance.
- The specified substance, as well as the amount and duration of its use, is known to be capable of producing disturbances in impulse control (see the list above and Table 6.14, p. 454).
- The symptoms and behaviours are not better accounted for by another mental disorder such as an impulse control disorder or a disorder due to addictive behaviours. Evidence supporting a diagnosis of another mental disorder would include an impulse control disturbance preceding the onset of the substance use, the disturbance persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-

existing mental disorder with impulse control disturbance (e.g. a history of prior episodes not associated with substance use).

- The symptoms and behaviours are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Additional clinical features for substance-induced mental disorders

- Substance-induced mental disorders may present with varying patterns of symptoms, depending on the specific substance used as well as characteristics of the user (e.g. genetics, metabolism, personality factors). Substance use in higher amounts or over longer periods of time is more likely to be associated with the development of a substance-induced mental disorder.
- Symptoms of substance-induced mental disorder usually resolve or improve after sustained cessation of substance use. Longer-lasting and in some cases permanent changes can occur in amnestic disorder due to psychoactive substances, including medications, and in dementia due to psychoactive substances, including medications. Perceptual disturbances that last for weeks, months or years (e.g. trails of images of moving objects, geometric illusions) can also occur as a result of hallucinogen use – primarily LSD – and are referred to as "posthallucinogen perception disorder" or "hallucinogen-induced persisting perception disorder".
- The duration of substance withdrawal for some substances can be protracted. For substances with more protracted withdrawal periods, the onset of symptoms of substance-induced mental disorder can occur up to several weeks after the cessation of substance use. Substance-induced mental disorder symptoms related to substances with more protracted withdrawal periods may also last for correspondingly longer periods of time.
- In cases in which multiple psychoactive substances are used, it is often challenging to distinguish which substance is the cause of the substance-induced mental disorder. When the specific etiological substance cannot be determined, a diagnosis of substance-induced mental disorder due to multiple specified psychoactive substances, including medications, may assigned. In cases of multiple psychoactive substance use in which more than one specific substance can be identified as a cause of the substance-induced mental disorder, the corresponding specific substance-induced mental disorder diagnoses should be given instead.

Boundary with normality (threshold) for substance-induced mental disorders

- Symptoms of substance-induced mental disorders should be differentiated from known side-effects of psychoactive medication that are not significantly impairing or distressing, and from transient physiological aftereffects of intoxication ("hangover effects"). The duration or severity of the symptoms in substance-induced mental disorders must be

in excess of side-effects (e.g. transient jitteriness as a side-effect of methylphenidate) or hangover effects (e.g. transient low mood following alcohol use) of the specified substance, and result in significant distress or impairment of functioning.

Boundaries with other disorders and conditions (differential diagnosis) for substance-induced mental disorders

Boundary with substance intoxication and substance withdrawal

Mental or behavioural symptoms that occur during substance intoxication or substance withdrawal should only be used as a basis for diagnosing a substance-induced mental disorder if the intensity or duration of the symptoms is substantially in excess of those that are characteristic of substance intoxication or substance withdrawal due to the specified substance (see Table 6.16, p. 484), and the symptoms are sufficiently severe to warrant specific clinical attention.

Boundary with episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use or substance dependence

The impact of repeated or continuous use of substances characteristic of harmful pattern of substance use and substance dependence may include substance-induced mental disorders. Substance-induced mental disorders can also be associated with a single episode of substance use. In such cases, a substance-induced mental disorder should be diagnosed together with a primary diagnosis of episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use or substance dependence.

Boundary with mental disorders not induced by substances

Substance-induced mental disorders are differentiated from mental disorders with similar features that are not induced by substances on the basis of their onset, course and clinical features. A diagnosis of substance-induced mental disorder requires evidence from history, physical or mental examination, or laboratory findings of recent substance use, intoxication or withdrawal. Most substance-induced mental disorders resolve or improve within several weeks of cessation of substance use. Mental disorders not induced by substances may precede the onset of substance use or may continue to be symptomatic during periods of sustained abstinence. The co-occurrence of substance use or withdrawal and onset of symptoms of mental disorders should not be taken as evidence for a presumptive diagnosis of a substance-induced mental disorder. Some people use substances to suppress symptoms of mental disorders (e.g. schizophrenia and other primary psychotic disorders, mood disorders, anxiety and fear-related disorders, personality disorders), and full symptomatic presentations only emerge upon cessation or reduction in substance use. Furthermore, substance use can exacerbate symptoms or precipitate an episode of a pre-existing mental disorder. Finally, substance use may be associated with – but not etiological for – new onset of symptoms of a mental disorder. Although a diagnosis of a substance-induced mental disorder should not be assigned under these circumstances, an additional diagnosis of episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use or substance dependence may still be appropriate.

Substance-induced mental disorders listed in other groupings

The following categories are included in other mental disorder groupings, and CDDR are provided in those sections, but they are cross-listed here for reference.

The following category is included in the ICD-11 grouping of catatonia:

Substance-induced catatonia

- 6A41 Catatonia induced by substances or medications (p. 204)

The following categories are included in the ICD-11 grouping of neurocognitive disorders:

Substance-induced amnestic disorder

- 6D72.1 Amnestic disorder due to psychoactive substances, including medications (p. 616)
  - 6D72.10 Amnestic disorder due to use of alcohol
  - 6D72.11 Amnestic disorder due to use of sedatives, hypnotics or anxiolytics
  - 6D72.12 Amnestic disorder due to other specified psychoactive substance, including medications
  - 6D72.13 Amnestic disorder due to use of volatile inhalants

Note: the order of the categories above is different from that of other parallel entities (e.g. substance-induced dementia, below), in which the "other specified" category is listed last. This difference is not meaningful; the categories should be used in the same way.

Substance-induced dementia

- 6D84 Dementia due to psychoactive substances, including medications (p. 626)
  - 6D84.0 Dementia due to use of alcohol
  - 6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics
  - 6D84.2 Dementia due to use of volatile inhalants
  - 6D84.Y Dementia due to other specified psychoactive substance

Other specified disorder due to psychoactive substance use

Available categories by substance class

6C40.Y	Other specified disorder due to use of alcohol
6C41.Y	Other specified disorder due to use of cannabis
6C42.Y	Other specified disorder due to use of synthetic cannabinoids
6C43.Y	Other specified disorder due to use of opioids
6C44.Y	Other specified disorder due to use of sedatives, hypnotics or anxiolytics
6C45.Y	Other specified disorder due to use of cocaine
6C46.Y	Other specified disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone
6C47.Y	Other specified disorder due to use of synthetic cathinones

6C48.Y	Other specified disorder due to use of caffeine
6C49.Y	Other specified disorder due to use of hallucinogens
6C4A.Y	Other specified disorder due to use of nicotine
6C4B.Y	Other specified disorder due to use of volatile inhalants
6C4C.Y	Other specified disorder due to use of MDMA or related drugs, including MDA
6C4D.Y	Other specified disorder due to use of dissociative drugs, including ketamine and PCP
6C4E.Y	Other specified disorder due to use of other specified psychoactive substance, including medications
6C4F.Y	Other specified disorder due to use of multiple specified psychoactive substances
6C4G.Y	Other specified disorder due to use of unknown or unspecified psychoactive substances

Essential (required) features

- The presentation is characterized by psychological, cognitive or behavioural symptoms that develop during or soon after intoxication with or withdrawal from a specified substance, or use or discontinuation of a psychoactive medication.
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the disorders due to substance use grouping.
- The intensity or duration of the symptoms is substantially in excess of disturbances that are characteristic of intoxication or withdrawal due to the specified substance.
- The symptoms are not better accounted for by another mental disorder such as schizophrenia or another primary psychotic disorder, or a mood disorder. Evidence supporting a diagnosis of another mental disorder would include the symptoms preceding the onset of the substance use, the symptoms persisting for a substantial period of time after cessation of the substance or medication use or withdrawal (e.g. 1 month or more depending on the specific substance), or other evidence of a pre-existing mental disorder (e.g. a prior history of the symptoms not associated with substance use).
- The symptoms are not a manifestation of another medical condition.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Disorders due to psychoactive substance use, unspecified

Available categories by substance class

6C40.Z	Disorder due to use of alcohol, unspecified
6C41.Z	Disorder due to use of cannabis, unspecified
6C42.Z	Disorder due to use of synthetic cannabinoids, unspecified
6C43.Z	Disorder due to use of opioids, unspecified

6C44.Z	Disorder due to use of sedatives, hypnotics or anxiolytics, unspecified
6C45.Z	Disorder due to use of cocaine, unspecified
6C46.Z	Disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone, unspecified
6C47.Z	Disorder due to use of synthetic cathinones, unspecified
6C48.Z	Disorder due to use of caffeine, unspecified
6C49.Z	Disorder due to use of hallucinogens, unspecified
6C4A.Z	Disorder due to use of nicotine, unspecified
6C4B.Z	Disorder due to use of volatile inhalants, unspecified
6C4C.Z	Disorder due to use of MDMA or related drugs, including MDA, unspecified
6C4D.Z	Disorder due to use of dissociative drugs, including ketamine and PCP, unspecified
6C4E.Z	Disorder due to use of other specified psychoactive substance, including medications, unspecified
6C4F.Z	Disorder due to use of multiple specified psychoactive substances, unspecified
6C4G.Z	Disorder due to use of unknown or unspecified psychoactive substances, unspecified

6C4H Disorders due to use of non-psychoactive substances

Disorders due to use of non-psychoactive substances are characterized by the pattern and consequences of non-psychoactive substance use. Non-psychoactive substances include laxatives, growth hormone, erythropoietin and non-steroidal anti-inflammatory drugs. They may also include proprietary or over-the-counter medicines and folk remedies.

Disorders due to use of non-psychoactive substances do not include disorders related to psychoactive substances such as anabolic steroids, antidepressants, medications with anticholinergic properties (e.g. benztropine), and some antihistamines. These should be classified under 6C4E Disorders due to use of other specified psychoactive substance, including medications.

6C4H.0 Episode of harmful use of non-psychoactive substances

Essential (required) features

- An episode of use of a non-psychoactive substance that has caused clinically significant damage to a person's physical health or mental health is required for diagnosis.
- Harm to the health of the individual occurs due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration.
- The harm to health is not better accounted for by a medical condition not caused by the substance or by another mental disorder.

Note: harm to physical health includes acute health problems resulting from non-psychoactive substance use such as dehydration or dyslipidemia, and exacerbation or decompensation of pre-existing chronic health problems such as hypertension, liver disease or peptic ulceration. Harm may also result from a harmful route of administration (e.g. non-sterile intravenous self-administration causing infections). Harm to mental health refers to psychological and behavioural symptoms following non-psychoactive substance use (e.g. severe depressive symptoms following dehydration and mineral loss from inappropriate use of laxatives).

Additional clinical features

- There must be explicit evidence of harm to the individual's physical or mental health. There must also be a clear causal relationship between the harm to health and the episode of non-psychoactive substance use in question.
- Non-psychoactive substance use may occur in the context of other mental disorders (e.g. use of laxatives in anorexia nervosa to reduce body weight, use of anabolic steroids in body dysmorphic disorder to increase muscle mass). An additional diagnosis of episode of harmful psychoactive substance use can be made if the specific episode of non-psychoactive substance use in question has resulted in clinically significant harm to the individual's physical or mental health.
- A diagnosis of episode of harmful use of non-psychoactive substances often signals an opportunity for intervention, including lower-intensity interventions that can be implemented in a wide range of settings aimed at reducing the likelihood of additional harmful episodes, or of progression to harmful pattern of non-psychoactive substance use.
- As more information becomes available indicating that an episode is part of a continuous or recurrent pattern of harmful non-psychoactive substance use, a diagnosis of episode of harmful psychoactive substance use should be changed to harmful pattern of non-psychoactive substance use.

Boundary with normality (threshold)

- The diagnosis of episode of harmful use of non-psychoactive substances requires clinically significant harm to the individual's physical or mental health. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting or transient depressed mood.
- An episode of non-psychoactive substance use may also cause social problems that do not constitute clinically significant harm to physical or mental health (e.g. arguments with loved ones). A diagnosis of episode of harmful use of non-psychoactive substances should not be assigned in these circumstances.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with other specified hazardous drug use

The category other specified hazardous drug use from Chapter 24 on factors influencing health status or contact with health services may be assigned if the episode of non-psychoactive substance use in question appreciably increases the risk of harmful physical or mental health consequences to an extent that warrants attention and advice from health professionals, but has not resulted in specific identifiable harm to the individual's physical or mental health.

Boundary with harmful pattern of non-psychoactive substance use

If the harm to health is a result of a known episodic or continuous pattern of non-psychoactive substance use, harmful pattern of non-psychoactive substance use is the appropriate diagnosis rather than episode of harmful use of non-psychoactive substances. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months, or continuous use over at least 1 month. If harm is caused by use of a non-psychoactive substance but no information is available about the pattern or history of substance use, a diagnosis of episode of harmful use of non-psychoactive substances may be assigned until such time as evidence for a pattern of use is ascertained.

Boundary with injury, poisoning or certain other consequences of external causes

When use of a non-psychoactive substance results in injury or life-threatening symptoms (e.g. coma, severe cardiac, respiratory symptoms), a diagnosis from the grouping of harmful effects of substances in Chapter 22 on injury, poisoning or certain other consequences of external causes should also be assigned.

6C4H.1 Harmful pattern of use of non-psychoactive substances

Essential (required) features

- A pattern of repeated or continuous use of a non-psychoactive substance that has caused clinically significant damage to a person's physical health or mental health is required for diagnosis.
- Harm to the health of the individual occurs due to the direct or secondary toxic effects of the non-psychoactive substance on body organs and systems, or a harmful route of administration.
- The pattern of use of the relevant substance is evident over a period of at least 12 months if substance use is episodic or at least 1 month if use is continuous.
- The harm to health is not better accounted for by a medical condition not caused by the substance or by another mental disorder.

Note: harm to physical health includes acute or chronic health problems resulting from a pattern of non-psychoactive substance use such as testicular atrophy, cardiomegaly, and exacerbation

or decompensation of pre-existing chronic health problems such as hypertension, liver disease or peptic ulceration. Harm may also result from a harmful route of administration (e.g. non-sterile intravenous self-administration causing infections). Harm to mental health refers to psychological and behavioural symptoms following non-psychoactive substance use (e.g. severe depressive symptoms due to dehydration and mineral loss from inappropriate use of laxatives).

Course specifiers

6C4H.10 Harmful pattern of use of non-psychoactive substances, episodic

This category is assigned when all the diagnostic requirements for harmful pattern of use of non-psychoactive substances are met, and there is evidence of a pattern of recurrent episodic or intermittent use of the relevant non-psychoactive substance over a period of at least 12 months that has caused clinically significant harm to a person's physical or mental health.

6C4H.11 Harmful pattern of use of non-psychoactive substances, continuous

This category is assigned when all the diagnostic requirements for harmful pattern of use of non-psychoactive substances are met, and there is evidence of a pattern of continuous substance use (daily or almost daily) of the relevant non-psychoactive substance over a period of at least 1 month that has caused clinically significant harm to a person's physical or mental health.

6C4H.1Z Harmful pattern of use of non-psychoactive substances, unspecified

Additional clinical features for harmful pattern of use of non-psychoactive substances

- There must be explicit evidence of harm to the individual's physical or mental health. There must also be a clear causal relationship between the harm to health and the episode of non-psychoactive substance use in question.
- Non-psychoactive substance use may occur in the context of other mental disorders (e.g. use of laxatives in anorexia nervosa to reduce body weight, use of anabolic steroids in body dysmorphic disorder to increase muscle mass). An additional diagnosis of harmful pattern of non-psychoactive substance use can be made if the pattern of non-psychoactive substance use has resulted in clinically significant harm to the individual's physical or mental health.

Boundary with normality (threshold)

- The diagnosis of harmful pattern of use of non-psychoactive substances requires clinically significant harm to the individual's physical or mental health. Examples of impact on physical or mental health that would not be considered clinically significant include mild hangover, brief episodes of vomiting or transient depressed mood.
- A pattern of non-psychoactive substance use may also cause social problems that do not constitute clinically significant harm to physical or mental health (e.g. arguments with loved ones). A diagnosis of harmful pattern of use of non-psychoactive substances should not be assigned in these circumstances.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with episode of harmful non-psychoactive substance use

If the harm to health is a result of a single episode of non-psychoactive substance use rather than an episodic or continuous pattern of substance use, episode of harmful use of non-psychoactive substances is the appropriate diagnosis rather than harmful pattern of non-psychoactive substance use. Substance use is generally considered to be following a pattern if there has been at least episodic or intermittent use over a period of at least 12 months, or continuous use over at least 1 month. If harm is caused by use of a non-psychoactive substance but no information is available about the pattern or history of substance use, a diagnosis of episode of harmful use of non-psychoactive substances may be assigned until such time as evidence for a pattern of use is ascertained.

Boundary with injury, poisoning or certain other consequences of external causes

When use of a non-psychoactive substance results in injury or life-threatening symptoms (e.g. coma, severe cardiac or respiratory symptoms), a diagnosis from the grouping of harmful effects of substances in Chapter 22 on injury, poisoning or certain other consequences of external causes should also be assigned.

6C4Z Disorders due to substance use, unspecified

Secondary-parented categories in disorders due to substance use

Hazardous substance use

ICD-11 also includes a listing of hazardous substance use categories. These are not considered to be mental disorders but rather are included in the grouping "Problems associated with health behaviours" in Chapter 24 on factors influencing health status or contact with health services. Available categories for hazardous substance use due to specific substance classes are as follows.

Hazardous substance use categories may be used when the pattern of substance use appreciably increases the risk of harmful physical or mental health consequences, to the user or to others, to an extent that warrants attention and advice from health professionals, but no overt harm has yet occurred.

In hazardous substance use, the increased risk may be related to the frequency of substance use, to the amount used on a given occasion, or to risky behaviours associated with substance use or the context of use, from a harmful route of administration, or from a combination of these. The risk may be related to short-term effects of the substance or to longer-term cumulative effects on physical or mental health or functioning. Hazardous substance use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of substance use often persists in spite of awareness of increased risk of harm to the user or to others.

QE10 Hazardous alcohol use

QE11 Hazardous drug use

QE11.0 Hazardous use of opioids
QE11.1 Hazardous use of cannabis
QE11.2 Hazardous use of sedatives, hypnotics or anxiolytics
QE11.3 Hazardous use of cocaine
QE11.4 Hazardous use of stimulants, including amfetamines, methamfetamine and methcathinone
QE11.5 Hazardous use of caffeine
QE11.6 Hazardous use of MDMA or related drugs
QE11.7 Hazardous use of dissociative drugs, including ketamine and PCP
QE11.8 Hazardous use of other specified psychoactive substance
QE11.9 Hazardous use of unknown or unspecified psychoactive substances
QE11.Y Other specified hazardous drug use
QE11.Z Hazardous drug use, unspecified

QE12 Hazardous nicotine use

Disorders due to addictive behaviours

Disorders due to addictive behaviours are recognizable and clinically significant syndromes associated with distress or interference with personal functions that develop as a result of repetitive, rewarding behaviours other than the use of dependence-producing substances or sexual behaviours.

Disorders due to addictive behaviours include the following:

6C50 Gambling disorder
- **6C50.0** Gambling disorder, predominantly offline
- **6C50.1** Gambling disorder, predominantly online
- **6C50.Z** Gambling disorder, unspecified

6C51 Gaming disorder
- **6C51.0** Gaming disorder, predominantly online
- **6C51.1** Gaming disorder, predominantly offline
- **6C51.Z** Gaming disorder, unspecified

6C5Y Other specified disorder due to addictive behaviours

6C5Z Disorder due to addictive behaviours, unspecified.

Also listed in this section are two categories that are not considered to be mental disorders but may be used when the pattern of the relevant behaviour appreciably increases the risk of harmful physical or mental health consequences, to the individual or to others around this individual, to an extent that warrants attention and advice from health professionals but does not meet the diagnostic requirements for gambling disorder or gaming disorder.

Also listed in this section are two categories that are not considered to be mental disorders but may be used when the pattern of the relevant behaviour appreciably increases the risk of harmful physical or mental health consequences, to the individual or to others around this individual, to an extent that warrants attention and advice from health professionals but does not meet the diagnostic requirements for gambling disorder or gaming disorder.

QE21 Hazardous gambling or betting

QE22 Hazardous gaming

6C50 Gambling disorder

Essential (required) features

- A persistent pattern of gambling behaviour – which may be predominantly online (i.e. over the internet or similar electronic networks) or offline – is required for diagnosis, manifested in all of the following:
  - impaired control over gambling behaviour (e.g. onset, frequency, intensity, duration, termination, context);
  - increasing priority given to gambling behaviour to the extent that gambling takes precedence over other life interests and daily activities;
  - continuation or escalation of gambling behaviour despite negative consequences (e.g. marital conflict due to gambling behaviour, repeated and substantial financial losses, negative impact on health).
- The pattern of gambling behaviour may be continuous or episodic and recurrent, but is manifested over an extended period of time (e.g. 12 months).
- The gambling behaviour is not better accounted for by another mental disorder (e.g. a manic episode) and is not due to the effects of a substance or medication.
- The pattern of gambling behaviour results in significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for online or offline behaviour

Note: the order of specifiers is different than for 6C51 Gaming disorder.

6C50.0 Gambling disorder, predominantly offline

- This refers to gambling disorder that predominantly involves gambling behaviour that is not conducted over the internet or similar electronic networks (i.e. offline).

6C50.1 Gambling disorder, predominantly online

- This refers to gambling disorder that predominantly involves gambling behaviour that is conducted over the internet or similar electronic networks (i.e. online).

6C50.Z Gambling disorder, unspecified

Additional clinical features

- If symptoms and consequences of gambling behaviour are severe (e.g. gambling behaviours persist for days at a time without respite, or have major effects on functioning or health) and all other diagnostic requirements are met, it may be appropriate to assign a diagnosis of gambling disorder following a period that is briefer than 12 months (e.g. 6 months).
- Individuals with gambling disorder may make numerous unsuccessful efforts to control or significantly reduce gambling behaviour, whether self-initiated or imposed by others.
- Individuals with gambling disorder may increase the amount of money gambled over time to maintain or exceed previous levels of excitement, or to avoid boredom. They may also engage in a pattern of increasing intensity of gambling behaviour, increasing the amount of their wagers, or otherwise altering their gambling strategies in order to try to compensate for significant monetary loses ("chasing" their losses).
- Individuals with gambling disorder often experience urges or cravings to engage in gambling behaviour during other activities.
- Individuals with gambling disorder may exhibit substantial disruptions in diet, sleep, exercise and other health-related behaviours that can result in negative physical and mental health outcomes.
- Some individuals with gambling disorder may engage in deceitful behaviour to conceal the extent of their losses from loved ones, or attempt to obtain money in order to repay their debts.
- Some individuals with gambling disorder may engage in gambling behaviour in response to feelings of depression, anxiety, boredom, loneliness or other negative affective states. Although not diagnostically determinative, consideration of the relationship between emotional and behavioural cues and gambling behaviour can inform treatment planning.
- Gambling disorder commonly co-occurs with disorders due to substance use, mood disorders, anxiety and fear-related disorders, and personality disorder. Among individuals seeking treatment for gambling disorder, suicidal ideation and suicide attempts are common.
- In adults, gambling behaviour is associated with chronic medical conditions, obesity and poorer subjective health status.

Boundary with normality (threshold)

- Gambling disorder should not be diagnosed merely on the basis of repeated or persistent gambling (online or offline), such as in the context of social or professional gambling. Typically, these forms of gambling are limited to discrete periods, with monetary losses that are acceptable to the individual, and occur in the absence of the other characteristic features of the disorder.
- Daily gambling behaviour (e.g. buying lottery tickets) as a part of a routine or the use of gambling for purposes such as changing mood, alleviating boredom or facilitating social interaction in the absence of the other required features is not a sufficient basis for assigning a diagnosis of gambling disorder.

Course features

- The course of gambling disorder is variable, with recovery a common outcome even in the absence of intervention, especially for adolescents and young adults. However, for many, gambling disorder persists across the lifespan.
- Gambling behaviour can follow a continuous or episodic pattern. The intensity of gambling behaviour often fluctuates in relation to stress, depressive symptoms and substance use.
- Gambling disorder tends to develop gradually over the course of years, as frequency of gambling behaviour and monetary value of wagers increase.

Developmental presentations

- Gambling disorder typically has its onset in adolescence or young adulthood. Early onset is associated with higher levels of impulsivity. Prevalence of gambling disorder among adolescents tends to be higher than among adults.
- Onset of gambling disorder in older adulthood is uncommon.

Culture-related features

- Prevalence of gambling disorder varies by sociocultural background. For example, community-based prevalence in the United States is lower among immigrants than among United States-born individuals. Indigenous populations in several counties (e.g. Canada, New Zealand and the United States) appear to have higher prevalence than other ethnic groups, possibly due to greater financial hardship, the hope that gambling may help advance social goals, and the location of casinos on tribal lands.
- Endorsement of specific symptoms of gambling disorder may also vary cross-culturally. For example, among individuals with gambling problems in the United States, Asian Americans may be less likely to describe being preoccupied with gambling, while Latin Americans and African Americans may be more likely to describe attempts to reduce gambling.

Sex- and/or gender-related features

- Lifetime prevalence of gambling disorder is higher among males. In adulthood, the ratio of men to women diagnosed with gambling disorder is approximately 2:1. This gap is wider during adolescence (ratio of 4:1), which may reflect boys' tendency to start gambling earlier.

- Due to earlier onset, the course of gambling disorder is typically more protracted among men. Men also appear more likely to recover without intervention than women. Although onset among women tends to be later, symptoms often intensify more quickly. Women are more likely to seek treatment sooner than men, though treatment-seeking is low (less than 10%) across both genders.
- Women with gambling disorder are more likely to have co-occurring mood disorders or anxiety and fear-related disorders, whereas men are more likely to exhibit problems with substance abuse and externalizing behaviours.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hazardous gambling or betting

The category of hazardous gambling or betting from Chapter 24 on factors influencing health status or contact with health services may be assigned to individuals who exhibit problematic patterns of gambling without the other features of gambling disorder. Hazardous gambling or betting refers to a pattern of gambling that appreciably increases the risk of harmful physical or mental health consequences, to the individual or to others around the individual, that may require intervention or monitoring but is not considered a disorder.

Boundary with gaming disorder

Unlike gambling disorder, gaming disorder does not involve the betting of money or other valuables with the hope of obtaining something of greater value. If gaming behaviour is focused on wagers (e.g. internet poker), gambling disorder is generally the more appropriate diagnosis.

Boundary with bipolar and related disorders

Increased goal-directed activity – including impaired ability to control gambling behaviour – can occur during manic, mixed or hypomanic episodes. A diagnosis of gambling disorder should only be assigned if there is evidence of a persistent pattern of gambling behaviour that meets all diagnostic requirements for the disorder, and occurs outside of mood episodes. Some individuals with gambling disorder may exhibit symptoms while gambling that appear similar to those observed during manic episodes (e.g. euphoric mood and increased energy level). However, in mood episodes, such symptoms are not limited to the gambling context.

Boundary with obsessive-compulsive disorder

Gambling behaviour can sometimes be described as "compulsive" by lay people and also by some health professionals. Compulsions observed in obsessive-compulsive disorder are almost never experienced as inherently pleasurable; they typically occur in response to intrusive, unwanted and generally anxiety-provoking obsessions, which is not the case with gambling behaviour in gambling disorder.

Boundary with personality disorder

Some individuals with personality disorder with prominent dissocial features or prominent features of disinhibition may engage in problematic gambling behaviour. A diagnosis of gambling disorder can be assigned together with a personality disorder diagnosis if the diagnostic requirements for both are met.

Boundary with disorders due to substance use

Co-occurrence of gambling and substance use – particularly alcohol – is common. Intoxication due to some substances, including alcohol, can cause disinhibition and impaired judgement, which may exacerbate problematic gambling behaviour. A diagnosis of gambling disorder can be assigned together with a disorder due to substance use diagnosis if the requirements for both are met.

Boundary with the effects of psychoactive substances, including medications

Use of specific prescribed medications or illicit substances (e.g. dopamine agonists such as pramipexole for Parkinson disease or restless legs syndrome or illicit substances such as methamfetamine) can sometimes cause impaired control over gambling behaviour due to their direct effects on the central nervous system, with onset corresponding to use of the substance or medication. Gambling disorder should not be diagnosed in such cases.

6C51 Gaming disorder

Essential (required) features

- A persistent pattern of gaming behaviour ("digital gaming" or "video gaming") – which may be predominantly online (i.e. over the internet or similar electronic networks) or offline – is required for diagnosis, manifested in all of the following:
  - impaired control over gaming behaviour (e.g. onset, frequency, intensity, duration, termination, context);
  - increasing priority given to gaming behaviour to the extent that gaming takes precedence over other life interests and daily activities;
  - continuation or escalation of gaming behaviour despite negative consequences (e.g. family conflict due to gaming behaviour, poor scholastic performance, negative impact on health).
- The pattern of gaming behaviour may be continuous or episodic and recurrent, but is manifested over an extended period of time (e.g. 12 months).
- The gaming behaviour is not better accounted for by another mental disorder (e.g. a manic episode) and is not due to the effects of a substance or medication.
- The pattern of gaming behaviour results in significant distress or impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for online or offline behaviour

Note: the order of specifiers is different than for 6C50 Gambling disorder.

6C51.0 Gaming disorder, predominantly online

- This refers to gaming disorder that predominantly involves gaming behaviour that is conducted over the internet or similar electronic networks (i.e. online).

6C51.1 Gaming disorder, predominantly offline

- This refers to gaming disorder that predominantly involves gaming behaviour that is not conduced over the internet or similar electronic networks (i.e. offline).

6C51.Z Gaming disorder, unspecified

Additional clinical features

- If symptoms and consequences of gaming behaviour are severe (e.g. gaming behaviours persist for days at a time without respite or have major effects on functioning or health) and all other diagnostic requirements are met, it may be appropriate to assign a diagnosis of gaming disorder following a period that is briefer than 12 months (e.g. 6 months).
- Individuals with gaming disorder may make numerous unsuccessful efforts to control or significantly reduce gaming behaviour, whether self-initiated or imposed by others.
- Individuals with gaming disorder may increase the duration or frequency of gaming behaviour over time, or experience a need to engage in games of increasing levels of complexity or requiring increasing skills or strategy in an effort to maintain or exceed previous levels of excitement, or to avoid boredom.
- Individuals with gaming disorder often experience urges or cravings to engage in gaming during other activities.
- Upon cessation or reduction of gaming behaviour, often imposed by others, individuals with gaming disorder may experience dysphoria and exhibit adversarial behaviour or verbal or physical aggression.
- Individuals with gaming disorder may exhibit substantial disruptions in diet, sleep, exercise and other health-related behaviours that can result in negative physical and mental health outcomes, particularly if there are very extended periods of gaming.
- High-intensity gaming behaviour may occur as a part of online computer games that involve coordination among multiple users to accomplish complex tasks. In these cases, peer-group dynamics may contribute to the maintenance of intensive gaming behaviours. Regardless of the social contributions to the behaviour, the diagnosis of gaming disorder may still be applied if all diagnostic requirements are met.
- Gaming disorder commonly co-occurs with disorders due to substance use, mood disorders, anxiety and fear-related disorders, attention deficit hyperactivity disorder, obsessive-compulsive disorder and sleep-wake disorders.

Boundary with normality (threshold)

- Gaming disorder should not be diagnosed merely on the basis of repeated or persistent gaming (online or offline) in the absence of the other characteristic features of the disorder.
- Daily gaming behaviour as a part of a routine or the use of gaming for purposes such as developing skills and proficiency in gaming, changing mood, alleviating boredom or facilitating social interaction in the absence of the other required features is not a sufficient basis for assigning a diagnosis of gaming disorder.
- High rates and long durations of gaming behaviour (online or offline) that occur more commonly among specific age and social groups (e.g. adolescent males), and in particular contexts such as during the holidays or as part of organized gaming activities for entertainment in the absence of the other required features, are also not indicative of a disorder. Cultural, subcultural and peer-group norms should be considered when making a diagnosis.

Course features

- The course of gaming disorder is typically progressive, as the individual increasingly prioritizes gaming at the expense of other activities.
- Individuals with both autism spectrum disorder and attention deficit hyperactivity exhibit elevated rates of problematic gaming and gaming disorder. This appears to be related to preferences for particular types of stimuli, and possibly also to the use of gaming to regulate attention.

Developmental presentations

- Gaming disorder appears to be most prevalent among adolescent and young adult males aged 12–20 years. Available data suggest that adults have lower prevalence rates.
- Among adolescents, gaming disorder has been associated with elevated levels of externalizing (e.g. antisocial behaviour, anger control) and internalizing (e.g. emotional distress, lower self-esteem) problems. Among adults, gaming disorder has been associated with greater levels of depressive and anxiety symptoms.
- Adolescents with gaming disorder may be at increased risk of academic underachievement, school failure/dropout, and psychosocial and sleep problems.

Sex- and/or gender-related features

- Males appear to be more frequently affected by gaming disorder during both adolescence and adulthood.
- Although less frequently diagnosed with gaming disorder than adolescent boys, girls who meet the diagnostic requirements may be at greater risk of developing emotional or behavioural problems.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with hazardous gaming

The category of hazardous gaming from Chapter 24 on factors influencing health status or contact with health services may be assigned to individuals who exhibit problematic patterns of gaming behaviour without the other features of gaming disorder. Hazardous gaming refers to a pattern of gaming that appreciably increases the risk of harmful physical or mental health consequences, to the individual or to others around the individual, that may require some intervention or monitoring but is not considered to constitute a disorder.

Boundary with gambling disorder

Unlike gaming disorder, gambling disorder necessitates the betting of money or other valuables in the hope of obtaining something of greater value. If gaming behaviour is focused on wagers (e.g. internet poker), gambling disorder may be a more appropriate diagnosis.

Boundary with bipolar and related disorders

Increased goal-directed activity – including impaired ability to control gaming behaviour – can occur during manic, mixed or hypomanic episodes. A diagnosis of gaming disorder should only be assigned if there is evidence of a persistent pattern of gaming behaviour that meets all diagnostic requirements for the disorder, and occurs outside of mood episodes.

Boundary with obsessive-compulsive disorder

Gaming behaviour can sometimes be described as "compulsive" by lay people and also by some health professionals. Compulsions observed in obsessive-compulsive disorder are almost never experienced as inherently pleasurable; they typically occur in response to intrusive, unwanted and generally anxiety-provoking obsessions, which is not the case with gaming behaviour in gaming disorder.

Boundary with disorders due to substance use

Co-occurrence of gaming and substance use is common. Intoxication due to some substances may exacerbate problematic gaming behaviour. A diagnosis of gaming disorder can be assigned together with a disorder due to substance use diagnosis if the requirements for both are met.

Boundary with the effects of psychoactive substances, including medications

Use of specific prescribed medications or illicit substances (e.g. dopamine agonists such as pramipexole for Parkinson disease or restless legs syndrome or illicit substances such as methamfetamine) can sometimes cause impaired control over gaming behaviour due to their direct effects on the central nervous system, with onset corresponding to use of the substance or medication. Gaming disorder should not be diagnosed in such cases.

6C5Y Other specified disorder due to addictive behaviours

Essential (required) features

- The presentation is characterized by symptoms that share primary clinical features with other disorders due to addictive behaviours, including a persistent pattern of repetitive behaviour in which the individual exhibits impaired control over the behaviour (e.g. onset, frequency, intensity, duration, termination, context); increasing priority given to the behaviour to the extent that it takes precedence over other life interests and daily activities; and continuation or escalation of the behaviour despite negative consequences (e.g. family conflict, poor scholastic performance, negative impact on health).

  Note: impaired control over substance use or sexual behaviour is not included in this category.
- The pattern of repetitive behaviour may be continuous or episodic and recurrent, but is manifested over an extended period of time (e.g. 12 months).
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. autism spectrum disorder, an obsessive-compulsive or related disorder, a feeding or eating disorder, an impulse control disorder), are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6C5Z Disorder due to addictive behaviours, unspecified

Secondary-parented categories in disorders due to addictive behaviours

Hazardous gambling or betting and hazardous gaming

These categories are not considered to be mental disorders; instead, they are included in the grouping of problems associated with health behaviours in Chapter 24 on factors influencing health status or contact with health services.

QE21 Hazardous gambling or betting

Hazardous gambling or betting refers to a pattern of gambling or betting that appreciably increases the risk of harmful physical or mental health consequences to the individual or to others around the individual. The increased risk may be from the frequency of gambling or betting, the amount of time spent on these activities, the context of gambling or betting, the neglect of other activities and priorities, risky behaviours associated with gambling or betting or its context, the adverse consequences of gambling or betting, or a combination of these factors. The pattern of gambling or betting often persists in spite of awareness of increased risk of harm to the individual or to others. This category may be used when the pattern of gambling or betting warrants attention and advice from health professionals but does not meet the diagnostic requirements for gambling disorder.

QE22 Hazardous gaming

Hazardous gaming refers to a pattern of gaming, either online or offline, that appreciably increases the risk of harmful physical or mental health consequences to the individual or to others around the individual. The increased risk may be from the frequency of gaming, the amount of time spent on these activities, the neglect of other activities and priorities, risky behaviours associated with gaming or its context, the adverse consequences of gaming, or a combination of these factors. The pattern of gaming often persists in spite of awareness of increased risk of harm to the individual or to others. This category may be used when the pattern of gaming behaviour warrants attention and advice from health professionals but does not meet the diagnostic requirements for gaming disorder.

Impulse control disorders

Impulse control disorders are characterized by the repeated failure to resist a strong impulse, drive or urge to perform an act that is rewarding to the person – at least in the short term – despite longer-term harm either to the individual or to others, marked distress about the behaviour pattern, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Impulse control disorders involve a range of specific behaviours, including fire setting, stealing, sexual behaviour and explosive aggressive outbursts.

The episodes of the behaviour involved in impulse control disorders are often preceded by a rise in tension or affective arousal, which can also occur when attempting to resist the behaviour. The episodes of the behaviour are typically followed by pleasure, gratification or relief of tension. However, over the course of the disorder, individuals may report less awareness of building tension or arousal prior to the behaviour, or a reduction in pleasure or gratification following the behaviour. They may also experience feelings of guilt or shame following the behaviour. The behaviours involved in impulse control disorders are not fully attributable to another mental disorder, the direct central nervous system effects of a medication or substance – including substance intoxication and withdrawal – or another medical condition not classified under mental, behavioural and neurodevelopmental disorders.

Impulse control disorders include the following:

6C70	Pyromania
6C71	Kleptomania
6C72	Compulsive sexual behaviour disorder
6C73	Intermittent explosive disorder
6C7Y	Other specified impulse control disorder
6C7Z	Impulse control disorder, unspecified.

6C70 Pyromania

Essential (required) features

- The presentation is characterized by a recurrent failure to control strong impulses to set fires, resulting in multiple acts of, or attempts at, setting fire to property or other objects.
- There is a lack of apparent motive (e.g. monetary gain, revenge, sabotage, political statement, attracting recognition) for the acts of, or attempts at, fire setting.
- The individual exhibits persistent fascination or preoccupation with fire and related stimuli (e.g. watching fires, building fires, fascination with firefighting equipment).
- The individual experiences increased tension or affective arousal prior to instances of, or attempts at, fire setting.
- The individual experiences pleasure, excitement, relief or gratification during and immediately following the act of setting the fire, and while witnessing its effects or participating in its aftermath.
- Acts of, or attempts at, fire setting are not better accounted for by a disorder of intellectual development, another mental disorder (e.g. a manic episode) or substance intoxication.

Additional clinical features

- The impulse to set fires in individuals with pyromania may involve a careful planning phase to determine how to commit the act, with a concomitant gradual increase of tension or affective arousal; in other instances, fire setting may occur opportunistically without planning. In both cases, there is a lack of control over urges or impulses to set fires.
- In individuals with pyromania, fire setting may occur in response to feelings of depressed mood, anxiety, boredom, loneliness or other negative affective states. Although not diagnostically determinative, consideration of the relationship between emotional and behavioural cues and fire-setting behaviour may be an important aspect of treatment planning.
- Many individuals with pyromania exhibit impairments in social skills and a history of learning difficulties. Furthermore, individuals with pyromania – particularly women – often report histories of exposure to trauma, including sexual abuse, and self-harm.
- Conduct-dissocial disorder, attention deficit hyperactivity disorder and adjustment disorder are frequently associated with fire setting. Furthermore, pyromania appears commonly to co-occur with disorders due to substance use, gambling disorder, mood disorders, impulse control disorders, and disruptive behaviour and dissocial disorders.

Boundary with normality (threshold)

- Intentional fire setting can occur for a variety of reasons. Individuals may set fires for profit or to conceal a crime, as an act of revenge, to commit sabotage or make a political statement, or to attract recognition (e.g. deliberately setting a fire to then be the first one to discover it and put it out). Moreover, interest in fires is typical during early childhood, and young children may accidentally or intentionally set fires as a part of developmental experimentation (e.g. playing with matches, lighters, fire). A diagnosis of pyromania is not appropriate in such cases.

Course features

- Although the longitudinal course is unknown, pyromania appears to be chronic if untreated.
- Among individuals with pyromania, fire-setting events tend to be episodic, to wax and wane over time, and progressively to become more frequent and intense.

Developmental presentations

- The typical age of onset has not yet been definitively established, but current evidence suggests that most fire-setting behaviour begins during adolescence or early adulthood.
- Prevalence rates of pyromania, as distinct from fire setting and arson, suggest that the disorder is rare, particularly among children. In contrast, interest in fires among young children is common, and children may set fires accidentally (e.g. playing with matches) or purposefully without having the additional required diagnostic features of pyromania. A diagnosis of pyromania is not appropriate under these circumstances. However, fire-setting behaviour among children and adolescents is a significant problem, as nearly half of arson arrests are among young people below the age of 18 years. Lifetime prevalence of fire setting among adults is estimated at 1.13%, and is lowest among older adults.
- Limited information about the presentation of pyromania in adolescents is available, making it difficult to determine whether it is similar to the adult presentation of the disorder. The rising tension and relief reported among adults has not been as clearly documented among young people.

Sex- and/or gender-related features

- Pyromania and fire-setting behaviour is more common among males.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with attention deficit hyperactivity disorder

Individuals with attention deficit hyperactivity disorder – particularly children and adolescents – may set fires impulsively. However, impulsivity and disregard for consequences in attention deficit hyperactivity disorder are typically observed across multiple contexts and situations. Furthermore, individuals with attention deficit hyperactivity disorder do not exhibit the diagnostic features of preoccupation with fire, tension or affective arousal prior to fire setting, and gratification or relief once the act is committed that are characteristic of pyromania.

Boundary with bipolar type I disorder and schizophrenia and other primary psychotic disorders

Fire setting may, in rare instances, be associated with manic or mixed episodes in individuals with bipolar type I disorder. However, in such cases, fire-setting does not continue once the mood episode has ended, whereas in individuals with pyromania fire setting is not exclusively associated with manic or mixed episodes. Some individuals with delusions or hallucinations may set fires in response to command hallucinations or in the context of a delusional system, and pyromania should not be assigned in these cases.

Boundary with obsessive-compulsive disorder

Fire setting can sometimes be described as "compulsive" by lay people and also by some health professionals. Compulsions observed in obsessive-compulsive disorder are almost never experienced as inherently pleasurable; they typically occur in response to intrusive, unwanted and typically anxiety-provoking obsessions. In contrast, fire setting in pyromania is preceded by an increasing sense of tension or affective arousal, and is followed by an experience of pleasure, excitement or gratification.

Boundary with conduct-dissocial disorder and personality disorder with prominent dissocial features

Individuals with conduct-dissocial disorder and personality disorder with prominent dissocial features may set fires as part of a more pervasive pattern of antisocial behaviour, and often for discernible motives such as personal gain or revenge rather than to relieve tension or affective arousal. Individuals with pyromania do not typically exhibit antisocial behaviour apart from their fire setting.

Boundary with the effects of psychoactive substances, including medications

Fire setting may occur during substance intoxication. Pyromania should not be diagnosed if the fire setting is better accounted for by intoxication or the disinhibiting effects of alcohol,

drugs or medication. However, among individuals with pyromania, alcohol and substance use may be associated with fire setting. The presence of features of pyromania outside of episodes of intoxication is helpful in making this distinction.

Boundary with disinhibition in dementia and secondary personality change

Some individuals with dementia or secondary personality change may set fires as a part of a more general pattern of disinhibition of impulse control due to brain damage. A separate diagnosis of pyromania should not be assigned in such cases.

Boundary with disorders associated with impairment of cognitive or intellectual functioning

Some individuals with dementia, disorders of intellectual development, or cognitive or intellectual impairment associated with other conditions may set fires due to their impaired judgement without exhibiting the other features of pyromania.

6C71 Kleptomania

Essential (required) features

- The presentation is characterized by a recurrent failure to control strong impulses to steal objects.
- There is a lack of apparent motive for stealing objects (e.g. objects are not acquired for personal use or monetary gain).
- The individual experiences increased tension or affective arousal prior to instances of theft or attempted theft.
- The individual experiences pleasure, excitement, relief or gratification during and immediately following the act of stealing.
- Acts of theft or attempted theft are not better accounted for by a disorder of intellectual development, another mental disorder (e.g. a manic episode) or substance intoxication.

Additional clinical features

- Some individuals with kleptomania report amnesia or experience other dissociative symptoms during the act of stealing, and may have difficulty remembering their affective state prior to and immediately after the act, including whether they experienced mounting tension or arousal before and gratification or relief after stealing. Furthermore, over the course of the disorder, individuals may report less awareness of increased tension or arousal prior to incidents of stealing.
- In individuals with kleptomania, stealing may occur in response to feelings of depressed mood, anxiety, boredom, loneliness or other negative affective states. Although not

diagnostically determinative, consideration of the relationship between emotional and behavioural cues and stealing behaviour may be an important aspect of treatment planning.

- After stealing items, many individuals with kleptomania experience guilt or shame for having committed a theft, but these feelings do not prevent recurrence of the behaviour. Although individuals with kleptomania may desire the items they steal and have a practical use for such items, they do not need these items (e.g. they have multiples of the same item, they have more than adequate financial resources to purchase the stolen item).
- Rates of co-occurrence of mood disorders, anxiety and fear-related disorders, other impulse control disorders, substance use disorders, and obsessive-compulsive disorder among individuals with kleptomania are higher than in the general population.

Boundary with normality (threshold)

- Stealing behaviour is common, and most individuals who steal do so because they need or want something they cannot afford, as an act of mischief, or as an expression of anger or vengeance. The diagnosis of kleptomania requires that the individual does not need or could afford to buy the stolen items, but cannot resist the urge to steal. Moreover, in kleptomania, the theft is accompanied by a sense of tension before committing the act and a sense of gratification, pleasure or relief during and immediately after the act. Individuals who steal for monetary gain due to the financial implications of their substance use or gambling should not be diagnosed with kleptomania.

Course features

- The course of kleptomania is variable, and may take different forms: sporadic, with long periods of remission between brief episodes; episodic, with lengthy periods of stealing followed by periods of remission; or chronic, with fluctuations in intensity.
- Treatment-seeking individuals with kleptomania commonly report a long history of shoplifting (e.g. for more than 10 years) prior to seeking help.

Developmental presentations

- Onset of kleptomania may occur at any time, but is most common during late adolescence. Onset during late adulthood is rare.

Sex- and/or gender-related features

- Women are significantly more likely to be diagnosed with kleptomania.
- Gender differences in clinical presentation or severity of symptoms have not been observed.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with attention deficit hyperactivity disorder

Individuals with attention deficit hyperactivity disorder – particularly children and adolescents – may steal impulsively. However, impulsivity and disregard for consequences in attention deficit hyperactivity disorder are typically observed across multiple contexts and situations. Furthermore, individuals with attention deficit hyperactivity disorder do not exhibit tension or affective arousal prior to stealing, and gratification or relief once the theft is committed.

Boundary with bipolar type I disorder and schizophrenia and other primary psychotic disorders

Stealing may be associated with manic or mixed episodes in individuals with bipolar type I disorder. However, in such cases, stealing does not continue once the mood episode has ended, whereas in individuals with kleptomania stealing is not exclusively associated with mood episodes. Some individuals with delusions or hallucinations may steal in response to command hallucinations or in the context of a delusional system, and kleptomania should not be diagnosed in such cases.

Boundary with obsessive-compulsive disorder

Stealing in kleptomania can sometimes be described as "compulsive" by lay people and also by some health professionals. Compulsions observed in obsessive-compulsive disorder are almost never experienced as inherently pleasurable; they typically occur in response to intrusive, unwanted and typically anxiety-provoking obsessions. In contrast, stealing in kleptomania is preceded by an increasing sense of tension or affective arousal and is followed by an experience of pleasure, excitement or gratification.

Boundary with hoarding disorder

Some individuals with hoarding disorder steal objects as part of a pattern of excessive accumulation, and individuals with kleptomania may hoard stolen objects. However, individuals with hoarding disorder accumulate possessions to the extent that living spaces becoming so cluttered that their use or safety is compromised.

Boundary with conduct-dissocial disorder and personality disorder with prominent dissocial traits

Individuals with conduct-dissocial disorder and personality disorder with prominent dissocial features may commit theft as part of more pervasive pattern of antisocial behaviour, and often for discernible motives such as personal gain or revenge rather than to relieve symptoms of tension. Individuals with kleptomania do not exhibit antisocial behaviour other than stealing.

Boundary with the effects of psychoactive substances, including medications

Episodes of stealing may occur during substance intoxication. Individuals taking prescribed dopamine agonists – for example, for Parkinson disease or restless legs syndrome – may exhibit repetitive stealing behaviour with onset corresponding to use of the medication. Kleptomania should not be diagnosed if stealing is better accounted for by intoxication or the disinhibiting effects of alcohol, drugs or medication. However, among individuals with kleptomania, alcohol and substance use may be associated with acts of theft or attempted theft. The presence of features of kleptomania outside of episodes of intoxication is helpful in making this distinction.

Boundary with disinhibition in dementia and secondary personality change

Some individuals with dementia or secondary personality change may steal objects as a part of a more general pattern of disinhibition of impulse control due to brain damage. A separate diagnosis of kleptomania should not be assigned in such cases.

Boundary with disorders associated with impairment of cognitive or intellectual functioning

Some individuals with dementia, disorders of intellectual development, or cognitive or intellectual impairment associated with other conditions may steal objects due to their impaired judgement without exhibiting the other features of kleptomania.

6C72 Compulsive sexual behaviour disorder

Essential (required) features

- The presentation is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour, manifested in one or more of the following.
  - Engaging in repetitive sexual behaviour has become a central focus of the individual's life to the point of neglecting health and personal care or other interests, activities and responsibilities.
  - The individual has made numerous unsuccessful efforts to control or significantly reduce repetitive sexual behaviour.
  - The individual continues to engage in repetitive sexual behaviour despite adverse consequences (e.g. marital conflict due to sexual behaviour, financial or legal consequences, negative impact on health).
  - The individual continues to engage in repetitive sexual behaviour even when they derive little or no satisfaction from it.
- The pattern of failure to control intense, repetitive sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g. 6 months or more).
- The pattern of failure to control intense, repetitive sexual impulses or urges and resulting repetitive sexual behaviour is not better accounted for by another mental disorder (e.g. a manic episode) or other medical condition, and is not due to the effects of a substance or medication.

- The pattern of repetitive sexual behaviour results in marked distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort. Distress that is entirely related to moral judgements and disapproval about sexual impulses, urges or behaviours is not sufficient to meet this requirement.

Additional clinical features

- Compulsive sexual behaviour disorder may be expressed in a variety of behaviours, including sexual behaviour with others, masturbation, use of pornography, cybersex (internet sex), telephone sex and other forms of repetitive sexual behaviour.
- Individuals with compulsive sexual behaviour disorder often engage in sexual behaviour in response to feelings of depression, anxiety, boredom, loneliness or other negative affective states. Although not diagnostically determinative, consideration of the relationship between emotional and behavioural cues and sexual behaviour may be an important aspect of treatment planning.
- Individuals who make religious or moral judgements about their own sexual behaviour or view it with disapproval, or who are concerned about the judgements and disapproval of others or about other potential consequences of their sexual behaviour, may describe themselves as "sex addicts" or describe their sexual behaviour as "compulsive" or similar terms. In such cases, it is important to examine carefully whether such perceptions are only a result of internal or external judgements or potential consequences, or whether there is evidence that impaired control over sexual impulses, urges or behaviours and the other diagnostic requirements of compulsive sexual behaviour disorder are actually present.

Boundary with normality (threshold)

- There is wide variation in the nature and frequency of individuals' sexual thoughts, fantasies, impulses and behaviours. This diagnosis is only appropriate when the individual experiences intense, repetitive sexual impulses or urges that are experienced as irresistible or uncontrollable, leading to repetitive sexual behaviour, and when the pattern of repetitive sexual behaviour results in marked distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Individuals with high levels of sexual interest and behaviour (e.g. due to a high sex drive) who do not exhibit impaired control over their sexual behaviour and significant distress or impairment in functioning should not be diagnosed with compulsive sexual behaviour disorder. The diagnosis should also not be assigned to describe high levels of sexual interest and behaviour (e.g. masturbation) that are common among adolescents, even when this is associated with distress.
- Compulsive sexual behaviour disorder should not be diagnosed based on distress related to moral judgements and disapproval about sexual impulses, urges or behaviours that would otherwise not be considered to be indicative of psychopathology (e.g. a woman who believes that she should not have sexual impulses at all; a religious young man who believes

that he should never masturbate; a person who is distressed about their homosexual attraction or behaviour). Similarly, compulsive sexual behaviour disorder cannot be diagnosed based solely on distress related to real or feared social disapproval of sexual impulses or behaviours.

- Compulsive sexual behaviour disorder should not be diagnosed based solely on relatively brief periods (e.g. up to several months) of increased sexual impulses, urges and behaviours during transitions to contexts that involve increased availability of sexual outlets that previously did not exist (e.g. moving to a new city, a change in relationship status).

Course features

- Many individuals with compulsive sexual behaviour disorder report a history of sexually acting out during pre-adolescence or adolescence (e.g. risky sexual behaviour, masturbation to modulate negative affect, extensive use of pornography).

Developmental presentations

- Compulsive sexual behaviour disorder in adulthood has been associated with high rates of childhood traumas, including sexual abuse, with women reporting higher rates and severity of abuse.
- Adolescents and adults with compulsive sexual behaviour disorder commonly experience high rates of co-occurring mental, behavioural and neurodevelopmental disorders, including disorders due to substance use.
- Assessing the presence of compulsive sexual behaviour disorder may be particularly challenging during adolescence due to divergent views regarding the appropriateness of sexual behaviour during this life stage. Increased frequency of sexual behaviour or uncontrolled sexual urges associated with rapidly changing hormonal levels during this developmental stage may be considered to reflect normal adolescent experiences. Conversely, frequent or risky sexual behaviour among adolescents may be considered abnormal due to the potential for the behaviour to interfere with social and emotional development.

Culture-related features

- Cultural and subcultural variation may exist for compulsive sexual behaviour. Norms for what is considered appropriate sexual behaviour, activities judged unacceptable, and perceptions regarding gender roles influence sexual activity. These factors may affect norms regarding masturbation, use of pornography, having multiple sexual partners concurrently and the number of lifetime sexual partners.

- Culture shapes the distress caused by engaging in sexual behaviour and whether sexual activity is viewed as disordered. For example, in cultures where masculine ideals are associated with sexual conquest, higher rates of sexual behaviour may be considered normative, and should not be the primary basis for assigning a diagnosis.

Sex- and/or gender-related features

- Men are more likely to be diagnosed with compulsive sexual behaviour disorder.
- Women with compulsive sexual behaviour disorder are more likely than men to report a history of childhood sexual abuse.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with bipolar and related disorders

Increased sexual impulses, urges or behaviours and impaired ability to control them can occur during manic, mixed or hypomanic episodes. A diagnosis of compulsive sexual behaviour disorder should only be assigned if there is evidence of persistent failure to control intense, repetitive sexual impulses, urges or behaviours and the presence of all other diagnostic requirements outside of mood episodes.

Boundary with obsessive-compulsive disorder

Although the word "compulsive" is included in the name of this condition, sexual behaviour in compulsive sexual behaviour disorder is not considered to be a true compulsion. Compulsions in obsessive-compulsive disorder are almost never experienced as inherently pleasurable; they commonly occur in response to intrusive, unwanted and typically anxiety-provoking thoughts, which is not the case with sexual behaviour in compulsive sexual behaviour disorder.

Boundary with personality disorder

Some individuals with personality disorder may engage in repetitive sexual behaviour as a maladaptive regulation strategy (e.g. to prevent or reduce emotional distress or to stabilize their sense of self). Although both diagnoses can be assigned together, if the sexual behaviour is entirely accounted for by emotion dysregulation or other core features of personality disorder, an additional diagnosis of compulsive sexual behaviour disorder is not warranted.

Boundary with paraphilic disorders

The core feature of compulsive sexual behavioural disorder is a persistent pattern of failure to control intense repetitive sexual impulses or urges resulting in repetitive sexual behaviour that results in marked distress or impairment in functioning. Paraphilic disorders, on the other hand, are characterized by persistent and intense patterns of atypical sexual arousal manifested in sexual thoughts, fantasies, urges or behaviours, and have resulted in actions towards individuals whose age or status renders them unwilling or unable to consent, or are associated with marked distress or significant risk of injury or death. If an individual with a paraphilic disorder is able to exercise

some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted. If, however, the diagnostic requirements of both compulsive sexual behavioural disorder and a paraphilic disorder are met, both diagnoses may be assigned.

Boundary with the effects of psychoactive substances, including medications

Use of specific prescribed medications or illicit substances (e.g. dopamine agonists such as pramipexole for Parkinson disease or restless legs syndrome or illicit substances such as methamfetamine) can sometimes cause impaired control over sexual impulses, urges or behaviours due to their direct effects on the central nervous system, with onset corresponding to use of the substance or medication. Compulsive sexual behaviour disorder should not be diagnosed in such cases.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour may occur during substance intoxication. At the same time, co-occurrence of compulsive sexual behaviour disorder and substance use is common, and some individuals with compulsive sexual behaviour disorder use substances with the intention of engaging in sexual behaviour or to enhance pleasure from it. Distinguishing between compulsive sexual behaviour disorder and repetitive patterns of substance use with associated sexual behaviour is therefore a complex clinical judgement based on an assessment of the sequencing, context and motivations of the relevant behaviours. A diagnosis of compulsive sexual behaviour disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with dementia and medical conditions not classified under mental, behavioural and neurodevelopmental disorders

Some individuals with dementia, diseases of the nervous system or other medical conditions that have effects on the central nervous system may exhibit failure to control sexual impulses, urges or behaviours as a part of a more general pattern of disinhibition of impulse control due to neurocognitive impairment. A separate diagnosis of compulsive sexual behaviour disorder should not be assigned in such cases.

6C73 Intermittent explosive disorder

Essential (required) features

- The presentation is characterized by a pattern of recurrent, brief, explosive episodes involving verbal aggression (e.g. verbally attacking another person, temper outbursts, yelling) or physical aggression in an individual who is at least 6 years of age – when inhibition of angry outbursts is expected to have been attained – or equivalent developmental level is required for diagnosis. Episodes of physical aggression may result in significant damage or destruction of property or physical assault involving personal injury; however, such outcomes are not required for the diagnosis.
- The intensity of the outbursts or the degree of the aggressiveness is grossly out of proportion to the provocation or precipitating event or situation.

- The explosive outbursts must occur regularly over an extended period of time (e.g. at least 3 months), representing a persistent pattern of aggressive behaviour. A lower frequency threshold (e.g. several times over the course of a year) may be used for high-intensity outbursts with serious negative consequences, such as physically assaulting another person, whereas a higher frequency threshold (e.g. two or more times per week) should be used for episodes characterized by verbal aggression or non-assaultive and non-destructive physical aggression.
- The aggressive behaviours are clearly impulsive or reactive in nature, and represent a failure to control aggressive impulse. That is, the aggressive acts are not planned or instrumental in achieving a desired outcome.
- The frequency and intensity of explosive episodes is outside the limits of normal variation expected for the individual's age and developmental level.
- The explosive outbursts are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. autism spectrum disorder, attention deficit hyperactivity disorder, oppositional defiant disorder with chronic irritability-anger, conduct-dissocial disorder, delirium).
- The explosive outbursts are not due to the effects of a substance or medication on the central nervous system (e.g. amfetamines), including substance intoxication and withdrawal, or due to a disease of the nervous system.
- The behaviour pattern results in significant distress for the individual with the disorder, or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Additional clinical features

- Explosive episodes may be associated with affective symptoms (anger, irritability, rage) during aggressive outbursts. Sometimes the aggressive episodes are preceded by premonitory symptoms such as tremor or chest tightness, or a more general feeling of tension or arousal.
- Explosive outbursts in intermittent explosive disorder are typically triggered by perceived threats in social settings (even when there is no real threat but, for example, threat is perceived based on an inaccurate attribution of hostility to others), or by frustration when facing obstacles in the course of daily life.
- A wide array of aggressive behaviours could fulfil the requirements for intermittent explosive disorder, ranging from verbal aggression to physical assault and destruction of property.
- After the explosive episode, the individual often, but not always, experiences depressed mood or fatigue, or other negative emotions such as regret, remorse, guilt or shame.
- Some individuals with intermittent explosive disorder exhibit nonspecific abnormalities on neurological examination (e.g. "soft signs") and in EEGs that do not constitute a diagnosable disease of the nervous system. In the presence of such findings, intermittent explosive disorder may still be diagnosed if the diagnostic requirements are met.
- Many individuals with intermittent explosive disorder have a history of exposure to traumatic events, witnessing violence, or childhood physical abuse.
- Intermittent explosive disorder often co-occurs with depressive disorders, anxiety and fear-related disorders, disorders due to substance use, and eating disorders (especially those involving binge eating).

Boundary with normality (threshold)

- Aggressive outbursts – particularly verbal ones – are common, especially when an individual is under stress, and are not in themselves indicative of psychopathology. The mere occurrence of one or two isolated explosive episodes is not sufficient for the diagnosis, regardless of the severity or consequences of the behaviour. This diagnosis should only be considered when the intensity of the outbursts or the degree of the aggressiveness is grossly out of proportion to the provocation or precipitating event or situation, and the outbursts occur regularly over an extended period of time, representing a persistent pattern of aggressive behaviour.

Course features

- The mean age of onset of intermittent explosive disorder is between 10 and 16 years. Age of onset is typically earlier than common co-occurring disorders such as depressive disorders, anxiety and fear-related disorders, eating disorders and disorders due to substance use.
- Intermittent explosive disorder tends to exhibit a persistent course over many years. Aggressive behaviour in general tends to diminish over time, and the prevalence of intermittent explosive disorder correspondingly diminishes over the lifespan.

Developmental presentations

- Early in the course of intermittent explosive disorder, children typically display temper tantrums associated with verbal outbursts and aggression against objects, although typically without serious destruction of objects or assault against others.
- During adolescence, explosive outbursts often escalate to include destruction of objects or property, or physical assault against others.

Culture-related features

- Variation in prevalence of intermittent explosive disorder may be related to cultural norms regarding emotion regulation. Some cultures emphasize emotional restraint, equanimity, interpersonal harmony and social conformity such that individuals suppress or mute overt expressions of hostility or anger. In other cultures, freer expressions of negative affect are more typical. Whether or not a verbal expression is considered aggressive should be evaluated within the context of what is normative within the individual's culture.

- Societies vary in the degree to which they consider anger a harmful emotion, associated with substantial personal and social risk. Some cultural concepts of distress are attributed to pent-up anger, such as *ataque de nervios* (attack of nerves) in Latin America and *hwa-byung* (anger illness) in the Republic of Korea. It may be appropriate to apply a diagnosis of intermittent explosive disorder to some behavioural patterns of *ataque de nervios* involving paroxysmal violence and destruction of property.
- The typical level of expressed emotionality varies cross-culturally, including by gender and age. Cultural minorities, immigrants or individuals in post-conflict settings may be at risk of being mislabelled as excessively angry because of this variation. Moreover, clinicians may misattribute anger to a single triggering event when it is in reaction to the accumulation of multiple environmental stressors (e.g. discrimination, losses, displacement, limited social support, powerlessness, injustice). Clinicians should consider the larger social context and how it may be related to the expression of anger before assigning a diagnosis.

Sex- and/or gender-related features

- Although it was originally believed that intermittent explosive disorder was much more prevalent among males, recent community surveys suggest similar prevalence rates by gender. However, serious physical assault is a more common manifestation of the disorder in males, whereas less serious physical and verbal aggression is more characteristic of females.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with autism spectrum disorder

Explosive outbursts with aggressive behaviours may occur in some individuals with autism spectrum disorder. These outbursts are usually associated with a specific trigger that is related to the core symptoms of autism spectrum disorder (e.g. a change in routine, aversive sensory stimulation, anxiety, rigidity when the individual's thoughts or behaviours are interrupted). Individuals with intermittent explosive disorder do not exhibit other features of social communication difficulties and restricted or repetitive behaviours that are characteristic of autism spectrum disorder.

Boundary with attention deficit hyperactivity disorder

Intermittent explosive disorder and attention deficit hyperactivity disorder are both characterized by impulsive behaviour. However, intermittent explosive disorder is specifically characterized by intermittent severe aggressive outbursts rather than ongoing generalized behavioural impulsivity that may be seen in attention deficit hyperactivity disorder. Both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with oppositional defiant disorder

Regularly occurring severe temper outbursts that are grossly out of proportion in intensity or duration to the provocation may also occur in the context of oppositional defiant disorder with chronic irritability-anger, particularly in response to demands by authority figures. In such cases,

an additional diagnosis of intermittent explosive disorder should not be assigned. Individuals with oppositional defiant disorder with chronic irritability-anger typically display other features of oppositional defiant disorder, including defiant, headstrong or vindictive behaviours, which are not characteristic of intermittent explosive disorder. In addition, individuals with intermittent explosive disorder are more likely to exhibit significant physical aggression.

Boundary with conduct-dissocial disorder

People with intermittent explosive disorder may come into conflict with other people and with law enforcement because of their explosive outbursts, but these episodes do not constitute a more general pattern of antisocial behaviour characteristic of conduct-dissocial disorder (e.g. rule violations, lying, theft). In addition, intermittent explosive disorder is characterized by impulsive aggression, while aggression in conduct-dissocial disorder is often premeditated and instrumental.

Boundary with personality disorder

Due to interpersonal, occupational and other consequences of a recurrent pattern of verbal and physical aggression, some individuals with intermittent explosive disorder are likely to meet the diagnostic requirements for personality disorder with prominent features of disinhibition. Both diagnoses may be assigned if the full diagnostic requirements for each are met, but the utility of assigning an additional diagnosis of personality disorder in such cases depends on the specific clinical situation.

Boundary with other mental, behavioural and neurodevelopmental disorders

Aggressive outbursts may occur as a part of a number of mental disorders (e.g. disorders specifically associated with stress, mood disorders, schizophrenia and other primary psychotic disorders). In general, an additional diagnosis of intermittent explosive disorder should not be given when the outbursts are better accounted for by another disorder.

Boundary with the effects of psychoactive substances, including medications

Explosive aggressive behaviours may occur during substance intoxication or withdrawal. Intermittent explosive disorder should not be diagnosed if the outbursts are solely attributable to intoxication or the disinhibiting effects of alcohol, drugs or medication. However, among individuals with intermittent explosive disorder, alcohol and substance use are commonly associated with episodes of aggressive behaviour. In these situations, the distinction should be made based on the presence of features of intermittent explosive disorder at times other than during episodes of intoxication.

Boundary with malingering

Some individuals who engage in recurrent acts of verbal or physical aggression may falsely report additional symptoms consistent with a diagnosis of intermittent explosive disorder, with the intent of obtaining a mental disorder diagnosis to avoid criminal charges or other negative consequences. Intermittent explosive disorder should not be diagnosed in such cases.

Boundary with dementia and other medical conditions

The diagnosis of intermittent explosive disorder should not be assigned when the impulsive aggressive behaviours are entirely explained by dementia, a disease of the nervous system – including stroke – or another medical condition not classified under mental, behavioural and neurodevelopmental disorders (e.g. a brain tumour).

6C7Y Other specified impulse control disorder

Essential (required) features

- The presentation is characterized by symptoms that share primary clinical features with other impulse control disorders; that is, persistently repeated behaviours in which there is failure to resist an impulse, drive or urge to perform an act that is rewarding to the person – at least in the short term – despite negative consequences such as longer-term harm either to the individual or to others.
- The symptoms do not fulfil the diagnostic requirements for any other disorder in the impulse control disorders grouping.
- The symptoms are not characterized by recurrent and habitual actions directed at the integument (e.g. skin and hair), which should be classified under body-focused repetitive behaviour disorders.
- The symptoms are not characterized by gambling, gaming or other addictive behaviours.
- The symptoms are not better accounted for by another mental disorder (e.g. dementia, a disorder due to addictive behaviours, an obsessive-compulsive or related disorder).
- The symptoms or behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms or behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system (e.g. methamfetamine or dopamine agonists such as pramipexole for Parkinson disease or restless legs syndrome), including substance intoxication and withdrawal effects.
- The symptoms result in significant distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6C7Z Impulse control disorder, unspecified

Disruptive behaviour and dissocial disorders

Disruptive behaviour and dissocial disorders are characterized by persistent behaviour problems across multiple settings, with onset commonly, but not exclusively, during childhood. When present, these problems often persist into adulthood. These disorders are characterized by behaviours that range from those described as disruptive – that is, markedly and persistently defiant, disobedient, provocative or spiteful – to behaviours that are considered dissocial because they persistently violate the basic rights of others or major age-appropriate societal norms, rules or laws.

A majority of individuals commit isolated acts of aggression or rule violation at some point in their lives, and this does not warrant the diagnosis of a disruptive behaviour or dissocial disorder. In all cases, the behaviours characteristic of the disorders in this grouping must clearly depart from the normal range for the individual's age and gender, given their sociocultural context.

Disruptive behaviour and dissocial disorders may co-occur with other mental, behavioural and neurodevelopmental disorders. However, a separate diagnosis of a disruptive behaviour or dissocial disorder is not warranted if the disruptive behaviour is limited to symptomatic episodes of another mental disorder (e.g. defiant and noncompliant behaviour during a depressive episode), or if the behaviour is due to the effects of a substance or to another medical condition.

Disruptive behaviour and dissocial disorders are frequently associated with psychosocial environments that include family dysfunction; problems with peers, co-workers and romantic partners; and failure at school or work. Other psychosocial risk factors are common, such as peer rejection, deviant peer-group influences and parental mental disorder. Behaviours that are adaptive given the individual's environmental circumstances (e.g. running away from an abusive home; stealing in order to survive) should not be used as the sole basis for these diagnoses.

Disruptive behaviour and dissocial disorders include the following:

6C90 Oppositional defiant disorder

- 6C90.0 Oppositional defiant disorder, with chronic irritability-anger
- 6C90.1 Oppositional defiant disorder, without chronic irritability-anger
- 6C90.Z Oppositional defiant disorder, unspecified

6C91 Conduct-dissocial disorder

- 6C91.0 Conduct-dissocial disorder, childhood onset
- 6C91.1 Conduct-dissocial disorder, adolescent onset
- 6C91.Z Conduct-dissocial disorder, unspecified

6C9Y Other specified disruptive behaviour or dissocial disorder

6C9Z Disruptive behaviour or dissocial disorder, unspecified.

In addition, the following specifiers may be applied to all disorders in the disruptive behaviour and dissocial disorders grouping, where *x* corresponds to the fourth character of the disorder code and *y* corresponds to the fifth character:

6C9*x*.*y*0 With limited prosocial emotions

6C9*x*.*y*1 With typical prosocial emotions

6C9*x*.*y*Z Unspecified

6C90 Oppositional defiant disorder

Essential (required) features

- A pattern of markedly noncompliant, defiant and disobedient behaviour that is atypical for individuals of comparable age, developmental level, gender and sociocultural context is required for diagnosis. The pattern of behaviour may include:
  - persistent difficulty getting along with others (e.g. arguing with authority figures; actively defying or refusing to comply with requests, directives or rules; deliberately annoying others; blaming peers or co-workers for mistakes or misbehaviour);
  - provocative, spiteful or vindictive behaviour (e.g. antagonizing others, using social media to attack or mock others);
  - extreme irritability or anger (e.g. being touchy or easily annoyed, losing temper, angry outbursts, being angry and resentful).
- The behaviour pattern has persisted for an extended period of time (e.g. 6 months or more).
- The oppositional behaviours are not better accounted for by relational problems between the individual and a particular authority figure towards whom the individual is behaving in a defiant manner. Examples may include parents, teachers or supervisors who act antagonistically or place unreasonable demands on the individual.
- The behaviour pattern results in significant impairment in personal, family, social, educational or other important areas of functioning.

Specifiers for the presence or absence of chronic irritability-anger

Two specifiers indicating the presence or absence of chronic irritability-anger can be assigned to the diagnosis of oppositional defiant disorder.

6C90.0 Oppositional defiant disorder, with chronic irritability-anger

- All diagnostic requirements for oppositional defiant disorder are met.
- The presentation is characterized by prevailing, persistent irritable mood or anger that is atypical for individuals of comparable age, developmental level, gender and sociocultural context, including most of the following features:
  - often feeling angry or resentful, showing bitterness towards others, or feeling as if things are unfair;
  - often being touchy or easily annoyed, exhibiting oversensitivity or irritation to minimal or perceived provocations;
  - often losing temper, exhibiting angry verbal or behavioural outbursts – which may include tantrums, destructive behaviours or other forms of severe mood dysregulation.
- The anger or resentment, touchiness or annoyance, and loss of temper is out of proportion in intensity or duration to any provocation, and may be present independent of any apparent provocation.
- Chronic irritability-anger is characteristic of the individual's functioning nearly every day, are not limited to discrete periods, is observable across multiple settings or domains of functioning (e.g. home, school, social relationships), and is not restricted to the individual's relationship with their parents or guardians.
- The pattern of chronic irritability-anger is not better accounted for by another mental disorder (e.g. irritable mood in the context of manic or depressive episodes).
- Individuals with this subtype usually also display other characteristic features of oppositional defiant disorder, including defiant, headstrong or vindictive behaviours.

6C90.1 Oppositional defiant disorder, without chronic irritability-anger

- All diagnostic requirements for oppositional defiant disorder are met.
- The presentation is characterized by absence of prevailing, persistently angry or irritable mood. In these individuals, anger and irritability occur less frequently, and tend to be transitory, less severe and less often out of proportion to the provocation compared to individuals with chronic irritability-anger.

6C90.Z Oppositional defiant disorder, unspecified

Additional clinical features

- Although often identified through parental report of noncompliant behaviour, the negative and antagonistic aspects of oppositional defiant disorder also exert a broader negative influence on interactions with others outside the family. Oppositional defiant disorder is associated with peer rejection and interpersonal discord through the school years and into adulthood.
- Frequently, the oppositional defiant features have a provocative quality, such that individuals initiate confrontations and may be seen as excessively rude and uncooperative.
- Younger children (e.g. 3–5 years of age) are typically more closely supervised, and receive frequent instructions and limits imposed on them by authority figures (e.g. parents or other guardians, caregivers, teachers). As children grow older, direct demands by authority figures typically become less frequent. Moreover, others interacting with children or adolescents with oppositional defiant disorder may come to avoid placing demands on them due to their negative response. Therefore, a diagnosis is not precluded because oppositional or defiant behaviours occur relatively infrequently, as long as they characterize most interactions with authority figures.
- Adults with oppositional defiant disorder continue to experience conflictual relationships with parents and family members, and have generally poorer social support networks. This affects the number and quality of their friendships and romantic relationships. They typically struggle to function in the workplace due to difficulties in their interactions with supervisors and co-workers.
- Features of irritability and anger (e.g. being touchy or easily annoyed, losing temper, being angry and resentful) are sometimes the predominant characteristics of the clinical presentation. However, irritability and anger alone are neither necessary nor sufficient for the diagnosis. These symptoms must be accompanied by a pattern of markedly noncompliant, defiant and disobedient behaviour that is atypical for individuals of comparable age and developmental level. The presence of chronic irritability-anger is indicated using the corresponding specifier.
- Oppositional defiant disorder with chronic irritability-anger is not necessarily more severe or rare than oppositional defiant disorder without chronic irritability-anger. Rather, oppositional defiant disorder with chronic irritability-anger identifies a pattern of mood dysregulation that can range in severity from frequent and impairing tantrums to extreme presentations of the mood dysregulation.
- Individuals with oppositional defiant disorder may present with limited prosocial emotions. When assessing for oppositional defiant disorder, the clinician should also assess for limited prosocial emotions; if present, the appropriate specifier should be assigned (see p. 548). Individuals with oppositional defiant disorder with limited prosocial emotions are more likely to exhibit a more persistent and severe pattern of antisocial behaviour that may subsequently meet the diagnostic requirements for conduct-dissocial disorder.
- Oppositional defiant disorder in childhood frequently co-occurs with attention deficit hyperactivity disorder, conduct-dissocial disorder, and internalizing disorders such as depressive disorders or anxiety and fear-related disorders.

Boundary with normality (threshold)

- Transient noncompliance, defiance and disobedience including irritability or anger can occur within the normal range of behaviour as a part of typical development, or in response to increased demands on the developing child or changes in the child's environment (e.g. transition to a new school or city), or as a manifestation of normative anxiety in the context of specific tasks or situations (e.g. going to school and separating from parents for the first time). The presence of such behaviours should not be taken as evidence for a presumptive diagnosis of oppositional defiant disorder. Oppositional defiant disorder should only be diagnosed when there is a persistent pattern of markedly noncompliant, defiant and disobedient behaviour that is atypical considering the individual's age, gender and sociocultural context.

Course features

- The heterogeneity of presentations in oppositional defiant disorder has meaningful clinical and prognostic implications. Oppositional defiant disorder can be a developmental precursor for the development of conduct-dissocial disorder, especially when the presentation of oppositional defiant disorder includes severely defiant or spiteful/vindictive behaviours. However, many children with oppositional defiant disorder do not subsequently develop conduct-dissocial disorder.
- A diagnosis of oppositional defiant disorder with chronic irritability-anger is associated with the subsequent development of depressive disorders and anxiety and fear-related disorders.

Developmental presentations

- Typical age of onset of oppositional defiant disorder is in middle childhood, with initial symptoms typically appearing at preschool age. Symptoms rarely emerge for the first time later than early adolescence.
- Prevalence rates of oppositional defiant disorder are estimated at 3.3% among children and adolescents (aged 6–18 years). Some evidence suggests that overall prevalence of oppositional defiant disorder decreases beginning in adolescence and young adulthood.
- Oppositional defiant disorder is more common among children and adolescents whose families have experienced substantial disruptions in caregiving relationships, or in which parenting practices tend to be harsh, inconsistent or neglectful.
- Although oppositional and argumentative behaviours are common in typically developing children, unlike in oppositional defiant disorder, these behaviours tend to be transient and do not consistently negatively affect the child's functioning and development.

- Oppositional defiant disorder has been associated with greater peer rejection, heightened interpersonal conflict, and increased risk of co-occurring and subsequent difficulties in adjustment throughout childhood and adulthood.

Culture-related features

- There is substantial variation in the prevalence of oppositional defiant disorder across cultures. These differences may be related to cultural norms regarding uncooperative or defiant behaviour in children. For example, cultures that value obedience highly may have a lower threshold for considering a child's behaviour to be noncompliant, defiant or disobedient. The behaviours relevant to assigning a diagnosis of oppositional defiant disorder should be evaluated in relation to social, cultural and subgroup norms.
- Variation in the prevalence of oppositional defiant disorder and conduct-dissocial disorder across cultural groups may be related to differences in family structure and behaviour. Lower prevalence may be associated with stricter disciplinary practices at home, strong emphasis on educational or occupational attainment, and cultural values that disapprove of an antisocial lifestyle.

Sex- and/or gender-related features

- Prevalence of oppositional defiant disorder is higher among school-aged boys than school-aged girls, but does not appear to differ by gender at other points across the lifespan.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with conduct-dissocial disorder

The behaviour problems associated with oppositional defiant disorder are largely characterized by interpersonal conflict with authority figures and difficulty getting along with others. In contrast, conduct-dissocial disorder is characterized by a repetitive and persistent pattern of more severe and dissocial behaviour, in which the basic rights of others or major age-appropriate social or cultural norms, rules or laws are violated (e.g. aggression towards people or animals, destruction of property, deceitfulness or theft, serious violations of rules). However, individuals with conduct-dissocial disorder often demonstrate a range or history of behaviour problems that may include the interpersonal difficulties characteristic of oppositional defiant disorder. Both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with attention deficit hyperactivity disorder

Individuals with attention deficit hyperactivity disorder often have difficulty following directions, complying with rules and getting along with others. When these disruptive behaviours are

better accounted for by inattention or hyperactivity-impulsivity (e.g. failure to follow long and complicated directions, difficulty remaining seated or staying on task when asked), oppositional defiant disorder should not be diagnosed. In oppositional defiant disorder, the pattern of noncompliance is characterized by disobedience, beyond problems with attention and behavioural inhibition. However, attention deficit hyperactivity disorder and oppositional defiant disorder commonly co-occur and both diagnoses may be assigned if the full diagnostic requirements for each are met.

Boundary with autism spectrum disorder

Noncompliant and other disruptive behaviours characteristic of oppositional defiant disorder should be distinguished from behaviour problems that are common among individuals with autism spectrum disorder. The key difference is that, in autism spectrum disorder, disruptive behaviours are often associated with specific environmental factors (e.g. sudden change in routine, aversive sensory stimulation), or the noncompliance is a consequence of the core symptoms of that disorder (e.g. social communication deficits, restricted, repetitive, inflexible patterns of behaviour, sensory sensitivities) rather than reflecting an intention to be provocative or spiteful. Individuals with oppositional defiant disorder do not typically exhibit the social communication deficits and restricted, repetitive and inflexible patterns of behaviour, interests or activities that are characteristic of autism spectrum disorder.

Boundary with mood disorders

It is common – particularly in children and adolescents – for patterns of noncompliance and symptoms of irritability/anger to occur as a feature of a mood episode. Specifically, noncompliance may result from a number of depressive symptoms (e.g. diminished interest or pleasure in activities, difficulty concentrating, hopelessness, psychomotor retardation, reduced energy). During manic, mixed or hypomanic episodes, individuals are less likely to follow rules and comply with directions. Moreover, in children and adolescents, depressive, manic or hypomanic mood can manifest as irritability. When the behaviour problems occur entirely in the context of mood episodes, a separate diagnosis of oppositional defiant disorder should not be assigned.

Boundary with anxiety and fear-related disorders

In children and adolescents, symptoms of anxiety and fear-related disorders can sometimes manifest as noncompliance, defiance and disobedience, including irritability or anger. For example, children may exhibit angry outbursts and refuse to comply with requests when presented with a task or a situation that makes them feel anxious (e.g. when a child with social anxiety disorder is asked to make a presentation in class). These behaviours are typically a manifestation of a desire on the part of the child or adolescent to avoid the feared situation or stimulus. Furthermore, children and adolescents with anxiety and fear-related disorders do not typically exhibit provocative, spiteful or vindictive behaviour. If the defiant behaviour occurs only in response to situations or stimuli that elicit anxiety, fear or panic, oppositional defiant disorder should not be diagnosed.

Boundary with intermittent explosive disorder

Regularly occurring severe temper outbursts that are grossly out of proportion in intensity or duration to the provocation are the core symptom of intermittent explosive disorder but may also occur in the context of oppositional defiant disorder with chronic irritability-anger. Individuals with oppositional defiant disorder with chronic irritability-anger typically display other features of oppositional defiant disorder, including defiant, headstrong or vindictive behaviours, which are not characteristic of intermittent explosive disorder. In addition, individuals with intermittent explosive disorder are more likely to exhibit significant physical aggression.

6C91 Conduct-dissocial disorder

Essential (required) features

- A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules or laws are violated is required for diagnosis. Typically, multiple behaviours are involved, including one or more of the following:
  - *aggression towards people or animals,* such as bullying, threatening or intimidating others, instigating physical fights, using weapons that can cause serious physical harm to others (such as a brick, broken bottle, knife or gun), physical cruelty to people, physical cruelty to animals, aggressive forms of stealing (e.g. mugging, purse snatching, extortion), or forcing someone into sexual activity;
  - *destruction of property,* such as deliberate fire setting with the intention of causing serious damage or deliberate destruction of others' property (e.g. purposely breaking other children's toys, breaking windows, scratching cars, slashing tires);
  - *deceitfulness or theft,* such as stealing items of value (e.g. shoplifting, forgery), lying to obtain goods or favours or to avoid obligations (e.g. "conning" others), or breaking into someone's house, building or car;
  - *serious violations of rules,* such as children or adolescents repeatedly staying out all night despite parental prohibitions, repeatedly running away from home, or often skipping school or work without permission.

- The pattern of behaviour must be persistent and recurrent, including multiple incidents of the types of behaviours described above over an extended period of time (e.g. at least 1 year). The mere commission of one or more delinquent acts is not sufficient for the diagnosis.
- The behaviour pattern results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

Specifiers for age of onset

Two subtypes related to age of onset can be specified in individuals who meet the diagnostic requirements for conduct-dissocial disorder.

6C91.0 Conduct-dissocial disorder, childhood onset

- All diagnostic requirements for conduct-dissocial disorder are met.
- One or more features of the disorder have clearly been present and persistent during childhood prior to adolescence (e.g. before 10 years of age).

6C91.1 Conduct-dissocial disorder, adolescent onset

- All diagnostic requirements for conduct-dissocial disorder are met.
- None of the features of the disorder were present prior to adolescence (e.g. before 10 years of age).

6C91.Z Conduct-dissocial disorder, unspecified

Additional clinical features

- Individuals with conduct-dissocial disorder may be part of a delinquent peer group where delinquent activities are often conducted in association with peers. This may be particularly common among those with adolescent onset.
- The relationship between conduct-dissocial disorder and oppositional defiant disorder has historically been conceptualized as hierarchical and developmental in nature, with conduct-dissocial disorder generally considered more severe than, and commonly preceded by, oppositional defiant disorder. However, conduct-dissocial disorder frequently co-occurs and can be diagnosed with oppositional defiant disorder, particularly among individuals with a more persistent history of behaviour problems.
- Individuals with conduct-dissocial disorder with limited prosocial emotions (see p. 548) and individuals with conduct-dissocial disorder, childhood onset, are at greater risk of exhibiting a more persistent and severe pattern of antisocial behaviour over time. However, the subtypes for age of onset and the specifier for prosocial emotions are distinct characteristics that should be considered separately. In particular, childhood onset does not necessarily indicate that the individual will exhibit limited prosocial emotions.
- Conduct-dissocial disorder frequently co-occurs with attention deficit hyperactivity disorder, developmental learning disorder, anxiety and fear-related disorders, mood disorders, and disorders due to substance use.

Boundary with normality (threshold)

- Engaging in political protests should not be regarded as indicating the presence of conduct-dissocial disorder.
- The behaviours that contribute to a diagnosis of conduct-dissocial disorder can include criminal offences, and may entail legal or disciplinary repercussions – particularly for adolescents and adults. At the same time, many individuals who commit such criminal offences do not exhibit a persistent and recurrent pattern of antisocial behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules or laws are violated. Criminal behaviours may occur impulsively or opportunistically, or in relation

to substance use or intoxication. Clinical assessment and diagnosis should focus on the broader pattern of behaviour rather than solely on the criminality of specific behaviours or incidents.

Course features

- Earlier age of onset and greater symptom severity are predictive of worse prognosis, with these individuals more likely to engage in criminal behaviour and substance abuse, and to experience additional co-occurring mental and behavioural disorder diagnoses during adulthood.
- The course of conduct-dissocial disorder is highly variable, with some individuals experiencing a full remission of symptoms by adulthood. Initial symptoms of conduct-dissocial disorder are typically less severe in form (e.g. lying), but may progress in their severity over time (e.g. assault). There are significant individual differences in course features and progression of symptoms over time.
- When conduct-dissocial disorder is present in adulthood, it has generally been preceded by a history of serious behaviour problems during childhood and adolescence.
- The persistence of conduct-dissocial disorder into adulthood is often marked by continuity in types of behaviour problems (e.g. property violations in contrast to theft). Individuals with conduct-dissocial disorder who are violent during adolescence typically continue to engage in more frequent violence than their peers in adulthood. Status offences (e.g. running away, truancy) are less relevant in adulthood, but are a risk factor for continuing rule-breaking behaviour and criminal arrest.

Developmental presentations

- Although onset of conduct-dissocial disorder can occur in early childhood during the preschool years, typical age of onset is during early to middle adolescence. Onset of conduct-dissocial disorder is rare after the age of 16 years.

Culture-related features

- Assessment of conduct problems should account for contextual factors to determine whether a diagnosis is appropriate. In some cultural settings, for example, school-aged children may be away from school for long periods of seasonal employment rather than for conduct reasons. Alternatively, in communities with high levels of organized violence (e.g. gangs) or in the midst of civil conflict or war (e.g. where children as recruited as soldiers), children may be coerced into participating in interpersonal violence or property theft, which they may carry out for their own survival. A diagnosis of conduct-dissocial disorder should not be assigned in such cases.

- Conduct-dissocial disorder in adolescents often co-occurs with disorders due to substance use – especially those associated with use of alcohol. The rates of co-occurrence are influenced by sociocultural variation in availability of substances.

Sex- and/or gender-related features

- Conduct-dissocial disorder is more common among males.
- Males with conduct-dissocial disorder are more likely to exhibit symptoms of stealing, vandalism, fighting and school discipline problems, whereas females are more likely to exhibit lying, truancy, substance abuse, absconding and prostitution.
- Males with conduct-dissocial disorder more commonly exhibit both physical and relational aggression, whereas females are more likely to exclusively exhibit relational aggression.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with oppositional defiant disorder

For a diagnosis of conduct-dissocial disorder to be assigned, the pattern of behaviour must be severe and dissocial (i.e. violating major rules, norms, or the rights of others), such that it extends beyond the noncompliant and defiant behaviours that are characteristic of oppositional defiant disorder. However, oppositional defiant disorder and conduct-dissocial disorder frequently co-occur, particularly among adolescents and individuals with a more persistent history of behaviour problems, and may be diagnosed together if the full diagnostic requirements for each are met.

Boundary with attention deficit hyperactivity disorder

Individuals with attention deficit hyperactivity disorder may exhibit disruptive behaviours as a result of their impulsivity or hyperactivity; however, these disruptive behaviours are not typically severe and dissocial in nature (i.e. they do not violate major rules, norms or the rights of others), and therefore would not warrant an additional diagnosis of conduct-dissocial disorder. However, conduct-dissocial disorder and attention deficit hyperactivity disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for each are met.

Boundary with mood disorders

Conduct problems, aggressive behaviours, risky behaviours and irritability/anger can occur in the context of mood episodes (depressive, manic, mixed or hypomanic). Moreover, in children and adolescents, depressive, manic or hypomanic mood can manifest as irritability. When the behaviour problems occur entirely in the context of mood episodes, a separate diagnosis of conduct-dissocial disorder is generally not warranted.

Boundary with intermittent explosive disorder

Individuals with intermittent explosive disorder may come into conflict with other people and the law because of their explosive outbursts, but these episodes do not constitute a more general pattern of antisocial behaviour characteristic of conduct-dissocial disorder (e.g. rule violations,

lying, theft). In addition, intermittent explosive disorder is characterized by impulsive aggression, while aggression in conduct-dissocial disorder is often premeditated and instrumental.

Boundary with personality disorder

Conduct-dissocial disorder is not a personality disorder, although it is related to specific personality disorder categories in the clinical and research nomenclature (i.e. dissocial personality disorder, antisocial personality disorder). Personality disorder is characterized by a relatively enduring and pervasive disturbance in how individuals experience and interpret themselves, others and the world that results in maladaptive patterns of cognition, emotional experience, emotional expression and behaviour. These maladaptive patterns lead to significant problems in psychosocial functioning that are particularly evident in interpersonal relationships, manifested across a range of personal and social situations (i.e. not limited to specific relationships or situations). Individuals with personality disorder may have prominent dissocial features as an aspect of personality traits. The diagnosis of conduct-dissocial disorder is made based on a recurrent pattern of antisocial behaviour that may range in duration from a discrete period lasting a number of months to a pattern that persists across the lifespan. Conduct-dissocial disorder and personality disorder can co-occur, and both may be diagnosed if the full diagnostic requirements for each are met.

Boundary with disorders due to substance use

If the pattern of dissocial behaviour is limited to obtaining or using illicit substances, or if the behaviour is exclusively related to the effects of intoxication, dependence or withdrawal, conduct-dissocial disorder should not be diagnosed, and a disorder due to substance use should be considered instead. At the same time, co-occurrence of episodes of dissocial behaviour and substance use is common among individuals with conduct-dissocial disorder. This distinction may therefore depend on a complex clinical judgement that takes into account the onset, sequencing and context of the relevant behaviours. However, conduct-dissocial disorder and disorders due to substance use frequently co-occur, and both may be diagnosed if the full diagnostic requirements for each are met.

Specifier applicable to oppositional defiant disorder and conduct-dissocial disorder

Specifiers for limited or typical prosocial emotions

- The *with limited prosocial emotions* specifier may be applied to individuals who meet the diagnostic requirements for oppositional defiant disorder or conduct-dissocial disorder and also exhibit a pattern of limited prosocial emotions sometimes referred to as "callous and unemotional traits". Individuals with these characteristics represent a minority of those with disruptive behaviour and dissocial disorders diagnoses. The *with limited prosocial emotions* specifier represents a relatively more severe and less common presentation of disruptive behaviour and dissocial disorders.

In evaluating prosocial emotions, it is important to obtain information from others who have known the individual for an extended period of time, in addition to the individual's self-report of their own behaviours and experience.

Limited or typical prosocial emotions in individuals with oppositional defiant disorder or conduct-dissocial disorder can be specified as follows.

6C9*x.y*0 with limited prosocial emotions

- In the context of a diagnosis of disruptive behaviour and dissocial disorders, this specifier represents the presence of a characteristic social-emotional pattern in which several of the following features are repeatedly manifested:
  - *limited or absent empathy or sensitivity* to others' feelings or concern for their distress – the individual is more concerned with how events and their own behaviours affect themselves than with how they affect others, even if they cause harm;
  - *limited or absent remorse, shame or guilt* over their own behaviour (unless prompted by being apprehended), lack of concern about the consequences of their actions on others and relative indifference towards the probability of punishment;
  - *limited or absent concern over poor/problematic performance* in school, work or other important activities – the individual putting forth little effort and blaming others for their poor performance;
  - *limited or shallow expression of emotions,* particularly positive or loving feelings towards others – the individual's emotional expression possibly appearing shallow, superficial, insincere or instrumental.
- This pattern is pervasive across situations and relationships (i.e. the specifier should not be applied based on a single characteristic, a single relationship or a single instance of behaviour).
- The pattern is persistent over time (e.g. at least 1 year).
- Among individuals with oppositional defiant disorder, those with limited prosocial emotions tend to display a particularly extreme and stable pattern of oppositional behaviours.
- Among individuals with conduct-dissocial disorder, those with limited prosocial emotions tend to display a particularly severe, aggressive and stable pattern of antisocial behaviours.

6C9*x.y*1 with typical prosocial emotions

- In the context of a diagnosis of disruptive behaviour and dissocial disorders, this specifier represents a more common pattern of oppositional defiant disorder or conduct-dissocial disorder that is not characterized by the features of limited prosocial emotions.
- Although some features similar to limited prosocial emotions (e.g. low concern, limited remorse) may be evident at times, they are generally infrequent, transitory and less pronounced, and do not represent a persistent pervasive pattern of social-emotional deficits.
- Most individuals with disruptive behaviour and dissocial disorders exhibit typical prosocial emotions.

6C9x.yZ	unspecified prosocial emotions

6C9Y Other specified disruptive behaviour or dissocial disorder

Essential (required) features

- The presentation is characterized by disruptive or dissocial symptoms that share primary clinical features with other disruptive behaviour and dissocial disorders (i.e. persistent behaviour problems across multiple settings that range from markedly and persistently defiant, disobedient, provocative or spiteful to those that persistently violate the basic rights of others or major age-appropriate societal norms, rules or laws).
- The disruptive or dissocial symptoms do not fulfil the diagnostic requirements for oppositional defiant disorder or conduct-dissocial disorder.
- The symptoms are not better accounted for by another mental, behavioural or neurodevelopmental disorder (e.g. attention deficit hyperactivity disorder, a mood disorder, an anxiety or fear-related disorder).
- The behaviour pattern has persisted for an extended period of time (e.g. 6 months or more).
- The symptoms and behaviours are not developmentally appropriate or culturally sanctioned.
- The symptoms and behaviours are not a manifestation of another medical condition, and are not due to the effects of a substance or medication on the central nervous system, including withdrawal effects.
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning.

6C9Z Disruptive behaviour or dissocial disorder, unspecified

Personality disorders and related traits

Personality refers to an individual's characteristic way of behaving and experiencing life, and of perceiving and interpreting themselves, other people, events and situations. Personality disorder is a marked disturbance in personality functioning, which is nearly always associated with considerable personal and social disruption. The central manifestations of personality disorder are impairments in functioning of aspects of the self (e.g. identity, self-worth, capacity for self-direction) and/or problems in interpersonal functioning (e.g. developing and maintaining close and mutually satisfying relationships, understanding others' perspectives, managing conflict in relationships). Impairments in self-functioning and/or interpersonal functioning are manifested in maladaptive (e.g. inflexible or poorly regulated) patterns of cognition, emotional experience, emotional expression and behaviour.

The following diagnostic requirements for personality disorder first present a set of essential features, all of which must be present to diagnose a personality disorder. Once the diagnosis of a personality disorder has been established, it should be described in terms of its level of severity:

6D10.0 Mild personality disorder.

6D10.1 Moderate personality disorder.

6D10.2 Severe personality disorder.

6D10.Z Personality disorder, severity unspecified.

Also listed in this grouping is:

QE50.7 Personality difficulty

Personality difficulty is not classified as a mental disorder but rather is listed in the grouping of problems associated with interpersonal interactions in Chapter 24 on factors influencing health status or contact with health services.

Personality disorder and personality difficulty can be further described using five trait domain specifiers. These describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance. As many as necessary to describe personality functioning should be applied.

Trait domain specifiers that may be recorded include the following:

6D11.0 Negative affectivity

6D11.1 Detachment

6D11.2 Dissociality

6D11.3 Disinhibition

6D11.4 Anankastia

More detailed guidance about the personality characteristics reflected in the trait domain specifiers is provided in the following sections.

Clinicians may also wish to add an additional specifier:

6D11.5 Borderline pattern

The *borderline pattern* specifier has been included to enhance the clinical utility of the classification of personality disorder. Specifically, use of this specifier may facilitate the identification of individuals who may respond to certain psychotherapeutic treatments.

A complete description of a particular case of personality disorder includes the rating of the severity level and the assignment of the applicable trait domain specifiers (e.g. mild personality disorder with negative affectivity and anankastia; severe personality disorder with dissociality and disinhibition.) The *borderline pattern* specifier is considered optional but, if used, should ideally be used in combination with the trait domain specifiers (e.g. moderate personality disorder with negative affectivity, dissociality and disinhibition, borderline pattern).

General diagnostic requirements for personality disorder

Essential (required) features

- An enduring disturbance characterized by problems in functioning of aspects of the self (e.g. identity, self-worth, accuracy of self-view, self-direction) and/or interpersonal dysfunction (e.g. ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) is required for diagnosis.
- The disturbance has persisted over an extended period of time (e.g. lasting 2 years or more).
- The disturbance is manifested in patterns of cognition, emotional experience, emotional expression and behaviour that are maladaptive (e.g. inflexible or poorly regulated).
- The disturbance is manifested across a range of personal and social situations (i.e. is not limited to specific relationships or social roles), although it may be consistently evoked by particular types of circumstances and not others.

- The symptoms are not due to the direct effects of a medication or substance, including withdrawal effects, and are not better accounted for by another mental disorder, a disease of the nervous system or another medical condition.
- The disturbance is associated with substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- Personality disorder should not be diagnosed if the patterns of behaviour characterizing the personality disturbance are developmentally appropriate (e.g. problems related to establishing an independent self-identity during adolescence) or can be explained primarily by social or cultural factors, including sociopolitical conflict.

Severity of personality disorder

The areas of personality functioning shown in Box 6.2 should be considered in making a severity determination for individuals who meet the general diagnostic requirements for personality disorder.

Box 6.2. Aspects of personality functioning that contribute to severity determination in personality disorder

Degree and pervasiveness of disturbances in functioning of aspects of the self

- Stability and coherence of one's sense of identity (e.g. extent to which identity or sense of self is variable and inconsistent or overly rigid and fixed)
- Ability to maintain an overall positive and stable sense of self-worth
- Accuracy of one's view of one's characteristics, strengths, limitations
- Capacity for self-direction (ability to plan, choose, and implement appropriate goals)

Degree and pervasiveness of interpersonal dysfunction across various contexts and relationships (e.g. romantic relationships, school/work, parent-child, family, friendships, peer contexts)

- Interest in engaging in relationships with others
- Ability to understand and appreciate others' perspectives
- Ability to develop and maintain close and mutually satisfying relationships
- Ability to manage conflict in relationships

Pervasiveness, severity and chronicity of emotional, cognitive and behavioural manifestations of the personality dysfunction

- Emotional manifestations
- Range and appropriateness of emotional experience and expression
- Tendency to be emotionally over- or underreactive
- Ability to recognize and acknowledge emotions that are difficult or unwanted by the individual (e.g. anger, sadness)
- Cognitive manifestations
- Accuracy of situational and interpersonal appraisals, especially under stress
- Ability to make appropriate decisions in situations of uncertainty
- Appropriate stability and flexibility of belief systems
- Behavioural manifestations
- Flexibility in controlling impulses and modulating behaviour based on the situation and consideration of the consequences
- Appropriateness of behavioural responses to intense emotions and stressful circumstances (e.g. propensity to self-harm or violence)

The extent to which the dysfunctions in the above areas are associated with distress or impairment in personal, family, social, educational, occupational or other important areas of functioning

6D10.0 Mild personality disorder

Essential (required) features

- All general diagnostic requirements for personality disorder are met.
- Disturbances affect some areas of functioning of the self but not others (e.g. problems with self-direction in the absence of problems with stability and coherence of identity or self-worth; see Box 6.2), or affect all areas but are of mild severity, and may not be apparent in some contexts.
- There are problems in many interpersonal relationships or in performance of expected occupational and social roles, but some relationships are maintained and/or some roles fulfilled.
- Specific manifestations of personality disturbances are generally of mild severity (see the examples below).
- Mild personality disorder is typically not associated with substantial harm to self or others.
- Mild personality disorder may be associated with substantial distress or with impairment in personal, family, social, educational, occupational or other important areas of functioning that is either limited to circumscribed areas (e.g. romantic relationships; employment) or present in more areas but of milder severity.

Examples of specific personality disturbances in mild personality disorder

Note: this list of examples is not exhaustive, and it is not intended to suggest that all items will be present in any single individual.

- The individual's sense of self may be somewhat contradictory and inconsistent with how others view them.
- The individual has difficulty recovering from injuries to self-esteem.
- The individual's ability to set appropriate goals and to work towards them is compromised; the individual has difficulty handling even minor setbacks.
- The individual may have conflicts with supervisors and co-workers, but is generally able to sustain employment.
- The individual's limitations in the ability to understand and appreciate others' perspectives create difficulties in development of close and mutually satisfying relationships.
- There may be estrangement in some relationships, but relationships are more commonly characterized by intermittent or frequent minor conflicts that are not so severe that they cause serious and longstanding disruption.
- Alternatively, relationships may be characterized by dependence and avoidance of conflict by giving in to others, even at some cost to themselves.
- Under stress, there may be some distortions in the individual's situational and interpersonal appraisals, but reality testing typically remains intact.

6D10.1 Moderate personality disorder

Essential (required) features

- All general diagnostic requirements for personality disorder are met.
- Disturbances affect multiple areas of functioning of the self (e.g. stability and coherence of identity, self-worth, self-direction; see Box 6.2) and are of moderate severity.
- There are marked problems in most interpersonal relationships, and the performance of most expected social and occupational roles is compromised to some degree.
- Relationships are likely to be characterized by conflict, avoidance, withdrawal or extreme dependency (e.g. few friendships maintained, persistent conflict in work relationships and consequent occupational problems, romantic relationships characterized by serious disruption or inappropriate submissiveness).
- Specific manifestations of personality disturbance are generally of moderate severity (see the examples below).
- Moderate personality disorder is sometimes associated with harm to self or others.
- Moderate personality disorder is associated with marked impairment in personal, family, social, educational, occupational or other important areas of functioning, although functioning in circumscribed areas may be maintained.

Examples of specific personality disturbances in moderate personality disorder

Note: this list of examples is not exhaustive, and it is not intended to suggest that all items will be present in any single individual.

- The individual's sense of self may become incoherent in times of crisis.
- The individual has considerable difficulty maintaining positive self-esteem. Alternatively, the individual has an unrealistically positive self-view that is not modified by evidence to the contrary.
- The individual exhibits poor emotion regulation in the face of setbacks, often becoming highly upset and giving up easily. Alternatively, the individual may persist unreasonably in pursuit of goals that have no chance of success.
- The individual may exhibit little genuine interest in or efforts towards sustained employment.
- Major limitations in the ability to understand and appreciate others' perspectives hinder development of close and mutually satisfying relationships.
- There are persistent problems in those relationships that do exist. They may be characterized by frequent, serious and volatile conflict, or be significantly unbalanced (e.g. the individual is highly dominant or highly submissive).
- Under stress there are marked distortions in the individual's situational and interpersonal appraisals. There may be mild dissociative states or psychotic-like beliefs or perceptions (e.g. paranoid ideas).

6D10.2 Severe personality disorder

Essential (required) features

- All general diagnostic requirements for personality disorder are met.
- There are severe disturbances in multiple areas of functioning of the self (e.g. sense of self may be so unstable that individuals report not having a sense of who they are, or so rigid that they refuse to participate in any but an extremely narrow range of situations; self-view may be characterized by self-contempt or be grandiose or highly eccentric; see Box 6.2).
- Problems in interpersonal functioning seriously affect virtually all relationships, and the ability and willingness to perform expected social and occupational roles is severely compromised or absent.
- Specific manifestations of personality disturbance are severe (see the examples below), and affect most, if not all, areas of personality functioning.
- Severe personality disorder is often associated with harm to self or others.
- Severe personality disorder is associated with severe impairment in all or nearly all areas of life, including personal, family, social, educational, occupational and other important areas of functioning.

Examples of specific personality disturbances in severe personality disorder

Note: this list of examples is not exhaustive, and it is not intended to suggest that all items will be present in any single individual.

- The individual's self-view is very unrealistic and is typically highly unstable or contradictory.
- The individual has serious difficulty with regulation of self-esteem, emotional experience and expression, and impulses, as well as other aspects of behaviour (e.g. perseveration, indecision).
- The individual is largely unable to set and pursue realistic goals.
- The individual's interpersonal relationships, if any, lack mutuality; they are shallow, extremely one-sided, unstable or highly conflictual, often to the point of violence. Family relationships are absent (despite having living relatives) or marred by significant conflict.
- The individual has extreme difficulty acknowledging difficult or unwanted emotions (e.g. does not recognize or acknowledge experiencing anger, sadness or other emotions).
- The individual is unwilling or unable to sustain regular work due to lack of interest or effort, poor performance (e.g. failure to complete assignments or perform expected roles, unreliability), interpersonal difficulties or inappropriate behaviour (e.g. fits of temper, insubordination).
- Under stress, there are extreme distortions in the individual's situational and interpersonal appraisals. There are often dissociative states or psychotic-like beliefs or perceptions (e.g. extreme paranoid reactions).

6D10.Z Personality disorder, severity unspecified

Secondary-parented category in personality disorders and related traits

QE50.7 Personality difficulty

As noted above, personality difficulty is not considered a mental disorder but rather is listed in the grouping of problems associated with interpersonal interactions in Chapter 24 on factors influencing health status or contact with health services. Personality difficulty refers to pronounced personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of personality disorder.

Personality difficulty is characterized by longstanding difficulties (e.g. at least 2 years) in the individual's way of experiencing and thinking about the self, others and the world. In contrast to personality disorder, personality difficulty is manifested in cognitive and emotional experience and expression only intermittently (e.g. during times of stress) or at low intensity. Personality difficulty is typically associated with some problems in functioning, but these are insufficiently severe to cause notable disruption in social, occupational and interpersonal relationships, or may be limited to specific relationships or situations.

Specifiers for prominent trait domains in personality disorder

Trait domain specifiers may be applied to personality disorders or personality difficulty to describe the characteristics of the individual's personality that are most prominent and that contribute to personality disturbance.

Trait domains are continuous with normal personality characteristics in individuals who do not have personality disorder or personality difficulty. They are not diagnostic categories but rather represent a set of dimensions that correspond to the underlying structure of personality.

As many trait domain specifiers may be applied as necessary to describe personality functioning. Individuals with more severe personality disturbance tend to have a greater number of prominent trait domains. However, a person may have a severe personality disorder and manifest only one prominent trait domain (e.g. detachment).

Trait domain specifiers that may be recorded include the following.

6D11.0 Negative affectivity

The core feature of the negative affectivity trait domain (sometimes referred to as "neuroticism") is the tendency to experience a broad range of negative emotions. Common manifestations of negative affectivity, not all of which may be present in a given individual at a given time, include the following.

Experiencing a broad range of negative emotions with a frequency and intensity out of proportion to the situation

Common negative emotions include – but are not limited to – anxiety, worry, depression, vulnerability, fear, anger, hostility, guilt and shame. The particular negative emotions that are most characteristic of any particular person vary across individuals, and are largely dependent on the presence or degree of other trait domains. For example, individuals with prominent dissociality are more likely to experience "externalizing" negative emotions (e.g. anger, hostility, contempt), whereas those with prominent detachment are more likely to experience "internalizing" negative emotions (e.g. anxiety, depression, pessimism, guilt).

Emotional lability and poor emotion regulation

Individuals with prominent negative affectivity are overreactive to both their own negative cognitions and to external events. They can become overwrought through their own thought processes, such as by ruminating over their shortcomings or past mistakes; over real or perceived threats, slights or insults; or over potential future problems. They are overreactive to external threats or criticism, problems and setbacks. They have low frustration tolerance and easily become visibly upset over even minor issues. They often experience and display multiple emotions simultaneously, or vacillate among a range of emotions in a short period of time. Once upset, they have difficulty regaining their composure and must rely on others or on leaving the situation to calm down.

Negativistic attitudes

Individuals with prominent negative affectivity typically reject others' suggestions or advice, arguing that enacting others' ideas would be too complicated or difficult; or that the suggested actions would not lead to the desired outcomes, or have a high likelihood of negative consequences. The manner of rejection is largely dependent on the individual's other traits. For example, those with prominent detachment are most likely to blame themselves for the likely difficulties or poor outcomes, whereas those with prominent dissociality are most likely to blame others for offering such bad ideas.

Low self-esteem and self-confidence

Individuals with prominent negative affectivity may exhibit low self-esteem and self-confidence in several different ways. These include avoidance of situations and activities that are judged to be too difficult (e.g. intellectually, physically, socially, interpersonally, emotionally), even despite evidence to the contrary; dependency, which may be manifested in frequent reliance on others for advice, direction and other kinds of help; envy of others' abilities and indicators of success; and, in more severe cases of low self-esteem, believing themselves to be useless, to have lived a worthless life, or to be incapable of accomplishing anything of value, which may be associated with suicidal ideation or behaviours.

Mistrustfulness

Interpersonally, this is typically manifested in suspicion that others have ill intent, and that neutral or even benign remarks and positive behaviours are hidden threats, slights or insults. Individuals with prominent negative affectivity tend to hold grudges and be unforgiving, even over long time periods. In non-interpersonal situations, this mistrustfulness typically takes the form of bitterness and cynicism (e.g. the belief that the "system is rigged").

6D11.1 Detachment

The core feature of the detachment trait domain is the tendency to maintain interpersonal distance (social detachment) and emotional distance (emotional detachment). Common manifestations of detachment, not all of which may be present in a given individual at a given time, include the following.

Social detachment

Social detachment is characterized by avoidance of social interactions, lack of friendships and avoidance of intimacy. Individuals with prominent detachment do not enjoy social interactions, and avoid all kinds of social contact and social situations as far as possible. They engage in little to no "small talk", even if initiated by others (e.g. at store check-out counters), seek out employment that does not involve interactions with others, and even refuse promotions if these would entail more interaction with others. They have few to no friends or even casual acquaintances. Their interactions with family members tend to be minimal and superficial. They rarely, if ever, engage in any intimate relationships, and are not particularly interested in sexual relations.

Emotional detachment

Emotional detachment is characterized by reserve, aloofness and limited emotional expression and experience. Individuals with prominent detachment keep to themselves as far as possible, even in obligatory social situations. They are typically aloof, responding to direct attempts at social engagement only briefly and in ways that discourage further conversation. Emotional detachment also encompasses emotional inexpressiveness, both verbally and non-verbally. Individuals with prominent detachment do not talk about their feelings, and it is difficult to discern what they might be feeling from their behaviours. In extreme cases, there is a lack of emotional experience itself, and they are non-reactive to either negative or positive events, with a limited capacity for enjoyment.

6D11.2 Dissociality

The core feature of the dissociality trait domain is disregard for the rights and feelings of others, encompassing both self-centredness and lack of empathy. Common manifestations of dissociality, not all of which may be present in a given individual at a given time, include the following.

Self-centredness

Self-centredness in individuals with prominent dissociality is manifested in a sense of entitlement, believing and acting as if they deserve – without further justification – whatever they want, preferentially above what others may want or need, and that this "fact" should be obvious to others. Self-centredness can be manifested both actively/intentionally and passively/unintentionally. Active – and usually intentional – manifestations of self-centredness include expectation of others' admiration, attention-seeking behaviours to ensure being the centre of others' focus, and negative behaviours (e.g. anger, "temper tantrums", denigrating others) when the admiration and attention that the individual expects are not granted. Typically, such individuals believe that they have many admirable qualities, that their accomplishments are outstanding, that they have achieved or will achieve greatness, and that others should admire them. Passive and unintentional manifestations of self-centredness reflect a kind of obliviousness that other individuals matter as much as oneself. In this aspect of dissociality, the individual's concern is with their own needs, desires and comfort, and those of others simply are not considered.

Lack of empathy

Lack of empathy is manifested in indifference to whether one's actions inconvenience others or hurt them in any way (e.g. emotionally, socially, financially, physically). As a result, individuals with prominent dissociality are often deceptive and manipulative, exploiting people and situations to get what they want and think they deserve. This may include being mean and physically aggressive. In the extreme, this aspect of dissociality can be manifested in callousness with regard to others' suffering and ruthlessness in obtaining one's goals, such that these individuals may be physically violent with little to no provocation, and may even take pleasure in inflicting pain and harm. Note that this aspect of dissociality does not necessarily imply that individuals with prominent dissociality do not cognitively understand the feelings of others; rather, they are not concerned about them and instead are likely to use this understanding to exploit others.

6D11.3 Disinhibition

The core feature of the disinhibition trait domain is the tendency to act rashly based on immediate external or internal stimuli (i.e. sensations, emotions, thoughts), without consideration of potential negative consequences. Common manifestations of disinhibition, not all of which may be present in a given individual at a given time, include the following.

Impulsivity

Individuals with prominent disinhibition tend to act rashly based on whatever is compelling at the moment, without consideration of negative consequences for themselves or others, including putting themselves or others at physical risk. They have difficulty delaying reward or satisfaction, and tend to pursue immediately available short-term pleasures or potential benefits. In this way, the trait is strongly associated with such behaviours as substance use, gambling and impulsive sexual activity.

Distractibility

Individuals with prominent disinhibition also have difficulty staying focused on important and necessary tasks that require sustained effort. They quickly become bored or frustrated with difficult, routine or tedious tasks, and are easily distracted by extraneous stimuli, such as others' conversations. Even in the absence of distractions, they have difficulty keeping their attention focused and persisting on tasks, and tend to scan the environment for more enjoyable options.

Irresponsibility

Individuals with prominent disinhibition are unreliable and lack a sense of accountability for their actions. As a result, they often do not complete work assignments or perform expected duties; they fail to meet deadlines, do not follow through on commitments and promises, and are late to or miss formal and informal appointments and meetings because they allow themselves to become engaged in something more compelling that has caught their attention.

Recklessness

Individuals with prominent disinhibition lack an appropriate sense of caution. They tend to overestimate their abilities and thus frequently do things that are beyond their skill level, without considering potential safety risks. Individuals with prominent disinhibition may engage in reckless driving or dangerous sports, or perform other activities that put them or others in physical danger without sufficient preparation or training.

Lack of planning

Individuals with prominent disinhibition prefer spontaneous over planned activities, leaving their options open should a more attractive opportunity arise. They tend to focus on immediate feelings, sensations and thoughts, with relatively little attention paid to longer-term or even short-term goals. When they do make plans, they often fail to follow through on them, so they are seldom able to reach long-term goals, and often fail to achieve even short-term goals.

6D11.4 Anankastia

The core feature of the anankastia trait domain is a narrow focus on one's rigid standard of perfection and of right and wrong, on controlling one's own and others' behaviour, and on controlling situations to ensure conformity to these standards. Common manifestations of anankastia, not all of which may be present in a given individual at a given time, include the following.

Perfectionism

Perfectionism is manifested in concern with social rules, obligations, norms of right and wrong; scrupulous attention to detail; rigid, systematic, day-to-day routines; excessive scheduling and planning; and an emphasis on organization, orderliness and neatness. Individuals with prominent anankastia have a very clear and detailed personal sense of perfection and imperfection that extends beyond community standards to encompass the individual's idiosyncratic notions of what is perfect and right. They believe strongly that everyone should follow all rules exactly and meet all obligations. Individuals with prominent anankastia may redo the work of others because it does not meet their perfectionistic standards. They have difficulty in interpersonal relationships because they hold others to the same standards as themselves, and are inflexible in their views.

Emotional and behavioural constraint

Emotional and behavioural constraint is manifested in rigid control over emotional expression, stubbornness and inflexibility, risk-avoidance, perseveration and deliberativeness. Individuals with prominent anankastic traits tightly control their own emotional expression, and disapprove of others' displays of emotion. They are inflexible and lack spontaneity, stubbornly insisting on following set schedules and adhering to plans. Their risk-avoidance includes both refusal to engage in obviously risky activities and a more general overconcern about avoiding potential negative consequences of any activity. They often perseverate and have difficulty disengaging from tasks because they are perceived as not yet perfect down to the last detail. They are highly deliberative and have difficulty making decisions due to concern that they have not considered every aspect and all alternatives to ensure that the right decision is made.

6D11.5 Borderline pattern

Note: the *borderline pattern* specifier has been included to enhance the clinical utility of the classification of personality disorder. There is considerable overlap between this pattern and information contained in the trait domain specifiers (most typically negative affectivity, dissociality and disinhibition). However, use of this specifier may facilitate the identification of individuals who may respond to certain psychotherapeutic treatments.

The *borderline pattern* specifier may be applied to individuals whose pattern of personality disturbance is characterized by a pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity, as indicated by five (or more) of the following:

- frantic efforts to avoid real or imagined abandonment;
- a pattern of unstable and intense interpersonal relationships, which may be characterized by vacillations between idealization and devaluation, typically associated with both strong desire for and fear of closeness and intimacy;
- identity disturbance, manifested in markedly and persistently unstable self-image or sense of self;
- a tendency to act rashly in states of high negative affect, leading to potentially self-damaging behaviours (e.g. risky sexual behaviour, reckless driving, excessive alcohol or substance use, binge eating);
- recurrent episodes of self-harm (e.g. suicide attempts or gestures, self-mutilation);
- emotional instability due to marked reactivity of mood – fluctuations of mood that may be triggered either internally (e.g. by one's own thoughts) or by external events, as a consequence of which, the individual experiences intense dysphoric mood states, which typically last for a few hours but may last for up to several days;
- chronic feelings of emptiness;
- inappropriate intense anger or difficulty controlling anger, manifested in frequent displays of temper (e.g. yelling or screaming, throwing or breaking things, getting into physical fights);
- transient dissociative symptoms or psychotic-like features (e.g. brief hallucinations, paranoia) in situations of high affective arousal.

Other manifestations of borderline pattern, not all of which may be present in a given individual at a given time, include the following:

- a view of the self as inadequate, bad, guilty, disgusting and contemptible;
- an experience of the self as profoundly different and isolated from other people, and a painful sense of alienation and pervasive loneliness;
- proneness to rejection hypersensitivity, problems in establishing and maintaining consistent and appropriate levels of trust in interpersonal relationships, and frequent misinterpretation of social signals.

Additional clinical features of personality disorder

- Personality disorder tends to arise when individuals' life experiences provide inadequate support for typical personality development, given the person's temperament (the aspect of personality that is considered to be innate, reflecting basic genetic and neurobiological processes). Thus, early life adversity is a risk factor for later development of personality disorder, as it is for many other mental disorders. However, it is not determinative: some individuals' temperament allows typical personality development despite an extremely adverse early environment. Nonetheless, in the context of a history of early adversity, ongoing behavioural, emotional or interpersonal difficulties suggest that a personality disorder diagnosis should be considered.

- Personality disorder often complicates and lengthens treatment of other clinical syndromes. Thus, poor or incomplete response to standard treatments of, for example, depressive disorders and anxiety and fear-related disorders may suggest the presence of personality disorder. Relatedly, persistent functional impairment after resolution of the clinical syndrome(s) being treated may suggest the presence of personality disorder.
- There is often considerable variability in the degree to which individuals and those around them agree that the individual's behaviours reflect a particular trait. If there is a marked discrepancy between an individual's self-description and the kinds of problematic behaviours exhibited, it often is helpful to interview someone who knows the person well. Marked differences between the individual's self-description and the informant's description may be suggestive of personality disorder.

Boundary with normality (threshold) for personality disorder

- Personality refers to an individual's characteristic way of behaving and experiencing life, and of perceiving and interpreting themselves, other people, events and situations. Personality is manifested most directly in how individuals think and feel about themselves and their interpersonal relationships, how they behave in response to those thoughts and feelings and in response to others' behaviours, and how they react to events in their lives and changes in the environment. An important characteristic of non-disordered personality is sufficient flexibility to react appropriately and to adapt to other people's behaviours, life events and changes in the environment. In personality disorder, patterns of cognition, emotional experience, emotional expression and behaviour are sufficiently maladaptive (e.g. inflexible or poorly regulated) that they result in substantial distress or significant impairment in personal, family, social, educational, occupational or other important areas of functioning.
- To warrant a diagnosis of personality disorder, personality disturbance must be manifested across a range of personal and social situations over an extended period of time (e.g. lasting 2 years or more). Behaviour patterns that are apparent only in the context of specific relationships, social roles or environmental circumstances, or that have lasted for a shorter period of time, are not a sufficient basis for a diagnosis of personality disorder. Instead, the possibility that such behaviour patterns are a response to environmental circumstances must be considered. A focus on problems in the relevant relationship or in the environment (e.g. with family or school) may be more appropriate than a diagnosis of personality disorder in such cases.

Course features

- Manifestations of personality disturbance tend to appear first in childhood, increase during adolescence, and continue into adulthood, although individuals may not come to clinical attention until later in life. Caution should be exercised in applying the diagnosis to children because their personalities are still developing.

- Overt behavioural manifestations of certain traits (dissociality, disinhibition) tend to decline over the course of adulthood. Other traits (detachment, anankastia) are less likely to do so. In both cases, functional impairment in broad areas of life (e.g. employment, interpersonal relationships) among people with personality disorder is often persistent.
- Personality disorder is relatively stable after young adulthood, but may change such that a person who had personality disorder during young adulthood no longer meets the diagnostic requirements by middle age.
- Much less commonly, a person who earlier did not have a diagnosable personality disorder develops one later in life. Emergence of personality disorder in older adults may be related to the loss of social support that had previously helped to compensate for personality disturbance.
- When there is a change in personality during middle adulthood or later in life, in the absence of change in the individual's environment, the possibility that the change is due to an underlying medical condition (e.g. secondary personality change) or to an unrecognized disorder due to substance use should be considered.

Developmental presentations

- Personality disorder is not typically diagnosed in pre-adolescent children. Over the course of their development, children integrate knowledge and experience about themselves and other people into a coherent identity and sense of self, as well as into individual styles of interacting with others. Different children vary substantially in the rate at which this integration occurs, and there is also substantial variation in the rate of integration within individuals over time. Therefore, it is very difficult to determine whether a pre-adolescent child exhibits problems in functioning in aspects of the self, such as identity, self-worth, accuracy of self-view or self-direction, because these functions are not fully developed in children. This is also true of interpersonal functions such as the ability to understand others' perspectives and to manage conflict in relationships.
- However, prominent maladaptive traits may be observable in pre-adolescent children and may be precursors to personality disorder in adolescence and adulthood. For example, individual differences in negative affectivity and disinhibition, as well as more specific features such as lack of empathy (an aspect of dissociality) and perfectionism (an aspect of anankastia) may be observed in very young children. However, such traits are also associated with the development of other mental disorders (e.g. mood disorders, anxiety and fear-related disorders) and should not be interpreted as childhood forms of personality disorder.
- Features of personality disorder manifest in similar ways in adolescents and in adults. However, in evaluating adolescents, it is important to consider the developmental typicality of the relevant behaviour patterns. For example, risk-taking behaviour, self-harm and moodiness are more common during adolescence than during adulthood. Therefore, thresholds for evaluating whether such behaviour patterns are indicative of personality disorder or of elevations in trait domains such as disinhibition and negative affectivity among adolescents should be correspondingly higher. The wide variability in normal adolescent development that may affect the expression of these behaviours or characteristics should also be considered.

Culture-related features

- Assessment of personality across cultures is challenging, requiring knowledge of normative personality function for the sociocultural context, variations in cultural concepts of the self, and evidence for consistent traits and behaviours across time and multiple social contexts.
- Culture shapes modes of self-construal, social presentation and levels of insight about behaviours that are related to personality development, including what are considered normal and abnormal personality states in a given setting. For example, children reared in collectivist societies may develop attachment styles and traits that are viewed as dependent or avoidant related to the norms of more individualistic cultures. In turn, traits of self-involvement that are accepted or positively valued in individualistic cultures may be considered narcissistic in collectivist cultures.
- Diagnosis of personality disorder must take into account the person's cultural background. Collateral information may be needed to assess whether certain disruptive self-states and behaviours are considered culturally uncharacteristic and therefore consistent with personality disorder in a given culture. In general, a diagnosis of personality disorder should be assigned only when the symptoms exceed thresholds that are normative for the sociocultural context.
- Among ethnic minority, immigrant and refugee communities, responses to discrimination, social exclusion and acculturative stress may be confused with personality disorder. For example, suspiciousness or mistrust may be common in situations of endemic racism and discrimination.
- Sociocultural contexts of exclusion affecting marginal social groups can evoke repeated attempts at self-affirmation or acceptance by others that are based on ambiguous or troubled relationships with authority figures and limited adaptability. These reactions may be confounded with manifestations of borderline pattern, such as impulsivity, instability, affective lability, explosive/aggressive behaviour or dissociative symptoms. However, a diagnosis should be assigned only when the symptoms exceed thresholds that are normative for the sociocultural context.

Sex- and/or gender-related features

- Available evidence indicates that gender distribution of personality disorder is approximately equal. However, there are significant gender differences in the behavioural expression of personality disorder and in the associated trait domains. Specifically, elevations on dissociality and disinhibition are more common among men, and elevations on negative affectivity are more common among women.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with personality difficulty

Individuals with pronounced personality characteristics that do not rise to the level of severity to merit a diagnosis of personality disorder may be considered to have personality difficulty if the characteristics affect treatment or health services. In contrast to personality disorder, personality difficulty is manifested only intermittently (e.g. during times of stress) or at low intensity. The difficulties are associated with some problems in functioning, but these are insufficiently severe to cause notable disruption in social, occupational and interpersonal relationships, and may be limited to specific relationships or situations.

Boundary with persistent mental disorders

A number of persistent and enduring mental disorders (e.g. autism spectrum disorder, schizotypal disorder, dysthymic disorder, cyclothymic disorder, separation anxiety disorder, obsessive-compulsive disorder, complex post-traumatic stress disorder, dissociative identity disorder) are characterized by enduring disturbances in cognition, emotional experience and behaviour that are maladaptive, manifested across a range of personal and social situations, and are associated with significant problems in functioning of aspects of the self (e.g. self-esteem, self-direction) and/or interpersonal dysfunction (e.g. ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships). Accordingly, individuals with these disorders may also meet the diagnostic requirements for personality disorder. Generally, individuals with such disorders should not be given an additional diagnosis of personality disorder unless additional personality features are present that contribute to significant problems in functioning of aspects of the self or interpersonal functioning. However, even in the absence of these additional features, there may be specific situations in which an additional diagnosis of personality disorder is warranted (e.g. entry into clinically indicated forms of treatment that are connected to a personality disorder diagnosis).

Boundary with conduct-dissocial disorder with limited prosocial emotions

Conduct-dissocial disorder is characterized by a recurrent pattern of behaviour in which the basic rights of others or major age-appropriate social or cultural norms, rules or laws are violated; this may range in duration from a discrete period lasting a number of months to one that persists across the lifespan. Conduct-dissocial disorder with limited prosocial emotions is further characterized by limited or absent empathy or sensitivity to others' feelings, and limited or absent remorse, shame or guilt. Conduct-dissocial disorder with limited prosocial emotions has features in common with personality disorder with dissociality, which is characterized by disregard for the rights and feelings of other, self-centredness and lack of empathy. Conduct-dissocial disorder may be diagnosed among pre-adolescent children, based on a shorter duration of symptoms than personality disorder. Among individuals with conduct-dissocial disorder, an additional diagnosis of personality disorder is warranted only if there are personality features in addition to dissociality that contribute to significant impairments in functioning of aspects of the self or problems in interpersonal functioning.

Boundary with secondary personality change

Secondary personality change is a persistent personality disturbance that represents a change from the individual's previous characteristic personality pattern that is judged to be a direct pathophysiological consequence of a medical condition not classified under mental, behavioural

and neurodevelopmental disorders, based on evidence from the history, physical examination or laboratory findings. Personality disorder is not diagnosed if the symptoms are due to another medical condition.

Boundary with disorders due to substance use

Disorders due to substance use often have pervasive effects on functioning of the self and interpersonal functioning. For example, they may exhibit problems with self-direction and self-esteem, difficulties and conflicts in relationships, dissocial behaviour related to obtaining or using drugs, and a wide range of other features that are commonly seen in individuals with personality disorder. If the personality disturbance is entirely accounted for by a disorder due to substance use, a diagnosis of personality disorder should not be given. However, if the personality disturbance is not entirely accounted for by the disorder due to substance use (e.g. if the personality disturbance preceded the onset of substance use) or if there are features of a personality disorder that are not accounted for by substance use (e.g. perfectionism), an additional diagnosis of personality disorder may be assigned.

Paraphilic disorders

Paraphilic disorders are characterized by persistent and intense patterns of atypical sexual arousal, manifested in sexual thoughts, fantasies, urges or behaviours, in which the focus of the arousal pattern involves others whose age or status renders them unwilling or unable to consent (e.g. pre-pubertal children, an unsuspecting individual being viewed through a window, an animal). Paraphilic disorders may also involve other atypical sexual arousal patterns if they cause marked distress to the individual, or may involve significant risk of injury or death.

Paraphilic disorders include the following:

- **6D30** Exhibitionistic disorder
- **6D31** Voyeuristic disorder
- **6D32** Paedophilic disorder
- **6D33** Coercive sexual sadism disorder
- **6D34** Frotteuristic disorder
- **6D35** Other paraphilic disorder involving non-consenting individuals
- **6D36** Other paraphilic disorder involving solitary behaviour or consenting individuals
- **6D3Z** Paraphilic disorder, unspecified.

In order for the paraphilic disorder to be diagnosed, the individual must have acted on the arousal pattern, or be markedly distressed by it.

Atypical patterns of sexual arousal that do not involve actions towards others whose age or status renders them unwilling or unable to consent or that are not associated with marked distress or significant risk of injury or death are not considered to be paraphilic disorders.

Many sexual crimes involve actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically, or in relation to substance use or intoxication. A diagnosis of a paraphilic disorder should not be assigned in such cases.

Paraphilic disorders frequently co-occur with a number of other mental disorders, including mood disorders, anxiety and fear-related disorders, and disorders due to substance use. It is also common for an individual to meet the diagnostic requirements for more than one paraphilic disorder.

Paraphilic disorders may be associated with arrest and incarceration, or impairment in functioning (e.g. at work, in interpersonal relationships), but these are not diagnostic requirements.

Paraphilic disorders should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and sexual acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.

General cultural considerations for paraphilic disorders

- Behavioural norms, thresholds of abnormality, and attitudes and interpretations regarding paraphilic disorders vary across cultures. Accurate assessment requires information about the etiology, function and consequences of the symptoms across cultural groups.

6D30 Exhibitionistic disorder

Essential (required) features

- A sustained, focused and intense pattern of sexual arousal – as manifested in persistent sexual thoughts, fantasies, urges or behaviours – that involves exposing one's genitals to an unsuspecting person in public places, usually without inviting or intending closer contact, is required for diagnosis.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.

Additional clinical features

- Exhibitionistic disorder should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and exhibitionistic acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.
- The diagnosis of exhibitionistic disorder is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of exhibitionistic behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of the individual's report of their sexual thoughts, fantasies or urges indicating

a sustained, focused and intense pattern of exhibitionistic sexual arousal, examples of other forms of evidence that may support the presence of an exhibitionistic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual behaviour; or planning and repeatedly seeking out opportunities to engage in exhibitionistic behaviour.

Boundary with normality (threshold)

- By definition, exhibitionistic disorder specifically excludes consensual exhibitionistic behaviours that occur with the consent of the individuals involved. Moreover, in some cultures there are socially sanctioned forms of public nudity, which do not constitute exhibitionistic disorder.

Course features

- Individuals with exhibitionistic disorder often report the onset of exhibitionistic sexual interest during adolescence.
- Exhibitionistic disorder is relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was previously assigned a diagnosis of exhibitionistic disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of exhibitionistic disorder due to increased impulse control and decreased sexual drive.

Culture-related features

- Laws defining what is considered exhibitionistic behaviour may vary across cultures, including by gender. In addition, cultures vary regarding acceptance of the practice of nudity and its appropriateness in specific contexts (e.g. pornography, saunas, nudist settings). In these contexts, certain behaviours may not be considered exhibitionistic by the cultural group.

Sex- and/or gender-related features

- Exhibitionistic disorder is much more common among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both exhibitionistic disorder and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Exhibitionistic disorder is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal that involves exposing one's genitals to an unsuspecting person in public places. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with exhibitionistic disorder is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour, including exhibitionistic behaviour, may occur during substance intoxication. Such episodes may not be a manifestation of a sustained, focused and intense sexual arousal pattern. At the same time, some individuals with exhibitionistic disorder may use substances with the intention of engaging in exhibitionistic behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of exhibitionistic disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of behaviours involving exposing oneself to non-consenting individuals is not sufficient to establish a diagnosis of exhibitionistic disorder. Rather, these behaviours must reflect a sustained, focused and intense pattern of sexual arousal. When this is not the case, other causes of the behaviour need to be considered. For example, exhibitionistic behaviours that do not reflect an underlying, persistent pattern of sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving exhibitionistic behaviour may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of exhibitionistic disorder requires these behaviours to be a manifestation of a sustained, focused and intense pattern of sexual arousal.

6D31 Voyeuristic disorder

Essential (required) features

- A sustained, focused and intense pattern of sexual arousal – as manifested in persistent sexual thoughts, fantasies, urges or behaviours – that involves observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity, is required for diagnosis.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.

Additional clinical features

- Voyeuristic disorder should not be diagnosed among children, and is not typically diagnosed among adolescents. Sexual curiosity is typical during adolescence, and observation of others may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.
- The act of observing in voyeuristic disorder is for the purpose of achieving sexual excitement, and does not necessarily involve an attempt to initiate sexual activity with the person being observed. Orgasm by masturbation may occur during the voyeuristic activity or later in response to memories of what the individual has seen. More recently, so-called "video voyeurs" have been described who use video equipment to record individuals in public or private places where there is an expectation of privacy.
- The diagnosis of voyeuristic disorder is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of voyeuristic behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of a report of the individual's sexual thoughts, fantasies or urges, examples of other forms of evidence supporting the presence of a voyeuristic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual behaviour; or planning and repeatedly seeking out opportunities to engage in voyeuristic behaviour.

Boundary with normality (threshold)

- By definition, voyeuristic disorder specifically excludes consensual voyeuristic behaviours that occur with the consent of the individual being observed.

Course features

- Individuals with voyeuristic disorder often report the onset of voyeuristic sexual interest during adolescence.
- Voyeuristic disorder is relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was assigned a diagnosis of voyeuristic disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of voyeuristic disorder due to increased impulse control and decreased sexual drive.

Sex- and/or gender-related features

- Voyeuristic disorder is much more prevalent among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both voyeuristic disorder and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Voyeuristic disorder is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal that involves stimuli such as observing an unsuspecting person who is naked, in the process of disrobing, or engaging in sexual activity. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with voyeuristic disorder is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour, including voyeuristic behaviour, may occur during substance intoxication. Such episodes may not be a manifestation of a sustained,

focused and intense sexual arousal pattern. At the same time, some individuals with voyeuristic disorder may use substances with the intention of engaging in voyeuristic behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of voyeuristic disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of behaviours involving observing an unsuspecting individual who is naked, in the process of disrobing, or engaging in sexual activity is insufficient to establish a diagnosis of voyeuristic disorder. Rather, these behaviours must reflect a sustained, focused and intense pattern of sexual arousal. When this is not the case, other causes of the behaviour need to be considered. For example, voyeuristic behaviours that do not reflect an underlying, persistent pattern of sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving voyeuristic behaviour may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of voyeuristic disorder requires these behaviours to be a manifestation of a sustained, focused and intense pattern of sexual arousal.

6D32 Paedophilic disorder

Essential (required) features

- A sustained, focused and intense pattern of sexual arousal – as manifested in persistent sexual thoughts, fantasies, urges or behaviours – involving pre-pubertal children is required for diagnosis.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.
- The diagnosis does not apply to sexual arousal and accompanying behaviour between pre- or post-pubertal children who are close in age.

Additional clinical features

- Paedophilic disorder should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and sexual acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.

- The diagnosis of paedophilic disorder is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of paedophilic behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of a report of the individual's sexual thoughts, fantasies or urges, examples of other forms of evidence supporting the presence of a paedophilic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual behaviour; planning and repeatedly seeking out opportunities to engage in paedophilic behaviour; or laboratory measures of relative viewing time (based on the finding that preferred sexual stimuli are gazed at longer than non-preferred sexual stimuli) and/or penile plethysmography.
- Some individuals with paedophilic disorder are attracted only to males, others only to females, and others to both.
- Some individuals act on their paedophilic urges only with family members, others only with people outside their immediate family, and others with both.

Boundary with normality (threshold)

- A broad range of sexual behaviour with peers may occur in children or adolescents. A diagnosis of paedophilic disorder should not be assigned on the basis of sexual behaviours among pre- or post-pubertal children or adolescents with peers who are close in age.

Course features

- Individuals with paedophilic disorder often report the onset of paedophilic sexual interest during adolescence.
- Paedophilic disorder is relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was assigned a diagnosis of paedophilic disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of paedophilic disorder due to increased impulse control and decreased sexual drive.

Culture-related features

- Cultures vary in their legal definition of what constitutes a child or adolescent. The Tanner stages – a scale of physical development, including primary and secondary sexual characteristics across the lifespan – may provide a more objective basis than age on which to base a definition.
- Cultures vary regarding the forms of affection that are considered appropriate between children and adults. For example, it is normative in some cultures for parents to kiss their children on the mouth as a sign of affection. Culturally normative behaviour should not be misattributed as inappropriate sexual activity.

Sex- and/or gender-related features

- Paedophilic disorder is much more prevalent among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both paedophilic disorder and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Paedophilic disorder is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal involving pre-pubertal children. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with paedophilic disorder is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with obsessive-compulsive disorder

Some individuals with obsessive-compulsive disorder experience intrusive thoughts and images about possible attraction or sexual abuse of children. These are typically highly distressing to the individual, and are not accompanied by sexual arousal; they therefore do not reflect an underlying paraphilic arousal pattern, even though the individual may be concerned that they do. These individuals may also experience other ego-dystonic thoughts or images with sexual content that are not experienced as sexually arousing.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour, including paedophilic behaviour, may occur during substance intoxication. Such episodes may not be a manifestation of a sustained,

focused and intense sexual arousal pattern. At the same time, some individuals with paedophilic disorder may use substances with the intention of engaging in paedophilic behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of paedophilic disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of sexual behaviours involving pre-pubertal children is not sufficient to establish a diagnosis of paedophilic disorder. Rather, these behaviours must reflect a sustained, focused and intense pattern of paedophilic sexual arousal. When this is not the case, other causes of the behaviour need to be considered. For example, sexual behaviours involving children that do not reflect an underlying, persistent pattern of paedophilic sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving paedophilic behaviour may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of paedophilic disorder requires these behaviours to be a manifestation of a sustained, focused and intense pattern of sexual arousal.

Boundary with sexually aggressive behaviour in adolescents

Some adolescents present with a history of sexually abusing younger children. The diagnosis of paedophilic disorder should be applied with caution to adolescents. Unless there is a persistent pattern of such behaviour, reflecting a sustained, focused and intense pattern of sexual arousal focused on pre-pubertal children, the diagnosis of paedophilic disorder is not appropriate.

6D33 Coercive sexual sadism disorder

Essential (required) features

- A sustained, focused and intense pattern of sexual arousal – as manifested in persistent sexual thoughts, fantasies, urges or behaviours – that involves the infliction of physical or psychological suffering on a non-consenting person is required for diagnosis.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.

Additional clinical features

- Coercive sexual sadism disorder should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual acts may occur impulsively or opportunistically during adolescence rather than representing a recurrent pattern of sexual arousal.
- The diagnosis of coercive sexual sadism disorder is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of coercive sadistic sexual behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of a report of the individual's sexual thoughts, fantasies or urges, examples of other forms of evidence supporting the presence of a coercive sadistic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual behaviour; planning and repeatedly seeking out opportunities to engage in coercive sadistic sexual behaviour; or laboratory measures of relative viewing time (based on the finding that preferred sexual stimuli are gazed at longer than non-preferred sexual stimuli) and/or penile plethysmography.

Boundary with normality (threshold)

- By definition, coercive sexual sadism disorder specifically excludes consensual sexual sadism and consensual masochism.

Course features

- Individuals with coercive sexual sadism disorder often report the onset of coercive sadistic sexual interest during adolescence.
- Coercive sexual sadism disorder is relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was assigned a diagnosis of coercive sexual sadism disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of coercive sexual sadism disorder due to increased impulse control and decreased sexual drive.

Sex- and/or gender-related features

- Coercive sexual sadism disorder is much more prevalent among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both coercive sexual sadism disorder and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Coercive sexual sadism disorder is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal that involves the infliction of physical or psychological suffering on a non-consenting person. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with coercive sexual sadism disorder is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with conduct-dissocial disorder

Conduct-dissocial disorder is characterized by a pervasive pattern of disregard for and violation of the rights of others. Coercive or sadistic sexual behaviours that occur in the context of conduct-dissocial disorder but that do not reflect an underlying, persistent pattern of sexual arousal involving the infliction of physical or psychological suffering should not be used as a basis for diagnosing coercive sexual sadism disorder.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour, including coercive sexual behaviour, may occur during substance intoxication. Such episodes may not be a manifestation of a sustained, focused and intense sexual arousal pattern. At the same time, some individuals with coercive sexual sadism disorder may use substances with the intention of engaging in coercive sexual behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of coercive sexual sadism disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of sexual behaviours involving the infliction of physical or psychological suffering on non-consenting individuals is not sufficient to establish a diagnosis of coercive sexual sadism disorder. Rather, these behaviours must reflect a sustained, focused and intense pattern of coercive sexual sadistic arousal. When this is not the case, other causes of the behaviour need to be considered. For example, coercive sexual behaviour may occur in the context of some mental disorders, such as a bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving coercive sexual behaviours may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of coercive sexual sadism disorder requires these behaviours to be a manifestation of a sustained, focused and intense pattern of sexual arousal.

6D34 Frotteuristic disorder

Essential (required) features

- A sustained, focused and intense pattern of sexual arousal – as manifested in persistent sexual thoughts, fantasies, urges or behaviours – that involves touching or rubbing against a non-consenting person is required for diagnosis.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.

Additional clinical features

- Frotteuristic disorder should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and sexual acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.
- The diagnosis of frotteuristic disorder is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of frotteuristic behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of a report of the individual's sexual thoughts, fantasies or urges, examples of other forms of evidence supporting the presence of an frotteuristic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual beh aviour; or planning and repeatedly seeking out opportunities to engage in frotteuristic behaviour.

Boundary with normality (threshold)

- By definition, frotteuristic disorder specifically excludes consensual touching or rubbing that occurs with the consent of the individual involved.

Course features

- Individuals with frotteuristic disorder often report the onset of frotteuristic sexual interest during adolescence.
- Frotteuristic disorder is relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was assigned a diagnosis of frotteuristic disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of frotteuristic disorder due to increased impulse control and decreased sexual drive.

Sex- and/or gender-related features

- Frotteuristic disorder is much more prevalent among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both frotteuristic disorder and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Frotteuristic disorder is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal that involves touching or rubbing against a non-consenting person. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with frotteuristic disorder is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with disorders due to substance use

Episodes of impulsive or disinhibited sexual behaviour, including frotteuristic behaviour, may occur during substance intoxication. Such episodes may not be a manifestation of a sustained, focused and intense sexual arousal pattern. At the same time, some individuals with frotteuristic

disorder may use substances with the intention of engaging in frotteuristic behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of frotteuristic disorder may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of behaviours involving sexual touching or rubbing against non-consenting individuals is not sufficient to establish a diagnosis of frotteuristic disorder. Rather, these behaviours must reflect a sustained, focused and intense pattern of sexual arousal. When this is not the case, other causes of the behaviour need to be considered. For example, inappropriate touching or rubbing against others that does not reflect an underlying, persistent pattern of sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving frotteuristic behaviour may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of frotteuristic disorder requires sexual touching or rubbing behaviours to be a manifestation of a sustained, focused and intense pattern of sexual arousal.

6D35 Other paraphilic disorder involving non-consenting individuals

Essential (required) features

- A sustained, focused and intense pattern of atypical sexual arousal – as manifested in sexual thoughts, fantasies, urges or behaviours – in which the focus of the arousal pattern involves others who are unwilling or unable to consent is required for diagnosis.
- The arousal pattern is not specifically described by any of the other named paraphilic disorders categories (e.g. arousal patterns involving corpses or animals).
- The presentation does not fulfil the diagnostic requirements of coercive sexual sadism disorder, paedophilic disorder, voyeuristic disorder, exhibitionistic disorder or frotteuristic disorder.
- The individual must have acted on these thoughts, fantasies or urges, or be markedly distressed by them.

Additional clinical features

- Other paraphilic disorder involving non-consenting individuals should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and sexual acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.

- A diagnosis of other paraphilic disorder involving non-consenting individuals is generally not adequately supported when the evidence indicating a sustained, focused and intense pattern of sexual arousal consists solely of a single or very limited number of instances of specific forms of sexual behaviour, as there may be other explanations for specific occurrences (e.g. intoxication, opportunity). In the absence of a report of the individual's sexual thoughts, fantasies or urges, examples of other forms of evidence supporting the presence of a paraphilic arousal pattern include a preference for specific types of pornography; preference over other forms of sexual behaviour; or planning and repeatedly seeking out opportunities to engage in the relevant paraphilic sexual behaviour.

Boundary with normality (threshold)

- Other paraphilic disorder involving non-consenting individuals specifically excludes sexual behaviours that occur with the consent of the person or people involved, as long as they are deemed to have the capacity to provide such consent.

Course features

- Individuals with paraphilic disorders often report the onset of paraphilic sexual interest during adolescence.
- Paraphilic disorders are relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours may change over time, such that an individual who was assigned a diagnosis of a paraphilic disorder no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing behavioural manifestations of paraphilic disorders due to increased impulse control and decreased sexual drive.

Sex- and/or gender-related features

- Paraphilic disorders are much more prevalent among men.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both other paraphilic disorder involving non-consenting individuals and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Other paraphilic disorder involving non-consenting individuals is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of sexual arousal, in which the focus of the arousal pattern involves others who are unwilling or unable to consent, that is not specifically described in any of the other named paraphilic disorders categories. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with other paraphilic disorder involving non-consenting individuals is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with disorders due to substance use

Episodes of sexual behaviour involving others whose age or status renders them unwilling or unable to consent may occur during substance intoxication. Such episodes may not be a manifestation of a sustained, focused and intense sexual arousal pattern. At the same time, some individuals with paraphilic disorders may use substances with the intention of engaging in sexual behaviour involving others whose age or status renders them unwilling or unable to consent that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of other paraphilic disorder involving non-consenting individuals may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders

The occurrence or a history of sexual behaviours involving others whose age or status renders them unwilling or unable to consent is not sufficient to establish a diagnosis of other paraphilic disorder involving non-consenting individuals. Rather, these sexual behaviours must reflect a sustained, focused and intense pattern of sexual arousal. When this is not the case, other causes of the sexual behaviour need to be considered. For example, sexual behaviours involving non-consenting individuals that do not reflect an underlying, persistent pattern of sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia.

Boundary with sexual crimes that do not involve a paraphilic disorder

Sexual crimes involving non-consenting individuals may consist of actions or behaviours that are not associated with a sustained underlying paraphilic arousal pattern. Rather, these behaviours may be transient and occur impulsively or opportunistically. The diagnosis of other paraphilic disorder involving non-consenting individuals requires these behaviours to be a manifestation of a sustained, focused and intense pattern of paraphilic sexual arousal.

6D36 Paraphilic disorder involving solitary behaviour or consenting individuals

Essential (required) features

- A sustained, focused and intense pattern of atypical sexual arousal – as manifested in sexual thoughts, fantasies, urges or behaviours – that involves consenting adults or solitary behaviour is required for diagnosis.
- One of the following two elements must be present.
  - The individual is markedly distressed by the nature of the arousal pattern and the distress is not simply a consequence of rejection or feared rejection of the arousal pattern by others.
  - The nature of the paraphilic behaviour involves significant risk of injury or death either to the individual (e.g. asphyxophilia or achieving sexual arousal by restriction of breathing) or to the individual's partner (e.g. consensual sadism that results in injuries requiring medical attention).
- If the diagnosis is assigned based on significant risk of injury or death, this risk should be directly and immediately connected to the paraphilic behaviour. For example, a presumed risk of increased exposure to sexually transmitted infections is not a sufficient basis for assigning this diagnosis.

Additional clinical features

- Paraphilic disorder involving solitary behaviour or consenting individuals should not be diagnosed among children, and should be diagnosed only with the utmost caution among adolescents. Sexual experimentation is typical during adolescence, and sexual acts may occur impulsively or opportunistically rather than representing a recurrent pattern of sexual arousal.
- Diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals generally requires a report of sexual thoughts, fantasies, urges and behaviours directly from the individual in order to document a sustained, focused and intense pattern of atypical sexual arousal, and the degree and sources of related distress.

Boundary with normality (threshold)

- The fact that an individual's pattern of sexual arousal deviates from social or cultural norms is not a basis for assigning a diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals. An arousal pattern that involves consenting adults or solitary behaviour, and that is not associated with marked distress that is not simply a consequence

of rejection or feared rejection of the arousal pattern by others or with a significant risk of injury or death, is not considered a disorder.

- The occurrence or a history of atypical sexual behaviours is not sufficient to establish a diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals. Some atypical sexual behaviours may occur impulsively or opportunistically, or as a means of personal and sexual exploration, and are not associated with a sustained underlying arousal pattern. The diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals requires these behaviours to be a manifestation of a sustained, focused and intense pattern of paraphilic sexual arousal, in addition to distress or significant risk of injury or death.
- When distress related to an arousal pattern involving consenting adults or solitary behaviour is entirely attributable to rejection or feared rejection of the arousal pattern by others (e.g. a partner, family, society), a diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals should not be assigned. Instead, categories from the grouping QA15 Counselling related to sexuality in Chapter 24 on factors influencing health status or contact with health services may be considered.
- This diagnosis should not be applied to individuals who are distressed about homosexual or bisexual sexual orientation. If an individual is presenting for treatment based on such distress, categories from the grouping QA15 Counselling related to sexuality in Chapter 24 on factors influencing health status or contact with health services may be considered. If the pattern of distress-related symptoms meets the diagnostic requirements for another mental disorder (e.g. adjustment disorder, a depressive disorder, an anxiety or fear-related disorder), that diagnosis should be assigned.

Course features

- Individuals with paraphilic arousal patterns involving solitary behaviour or consenting individuals often report the onset of paraphilic sexual interest during adolescence.
- Paraphilic arousal patterns are relatively stable after young adulthood, but sexual thoughts, fantasies, urges and behaviours, as well as any associated distress, may change over time, such that an individual who was assigned a diagnosis of a paraphilic disorder involving solitary behaviour or consenting individuals no longer meets the diagnostic requirements.

Developmental presentations

- Advancing age may be associated with decreasing paraphilic sexual arousal and decreasing related behavioural manifestations due to increased impulse control and decreased sexual drive.

Sex- and/or gender-related features

- Paraphilic arousal patterns involving solitary behaviour or consenting individuals are much more prevalent among men.
- Paraphilic arousal patterns involving masochism are more prevalent among women than other paraphilic arousal patterns. If other diagnostic requirements are met (e.g. marked distress or significant risk of injury or death), a masochistic paraphilic arousal pattern may be a part of the basis for diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with compulsive sexual behaviour disorder

Both paraphilic disorder involving solitary behaviour or consenting individuals and compulsive sexual behaviour disorder may involve repetitive sexual impulses, urges or behaviours that result in marked distress or impairment. Paraphilic disorder involving solitary behaviour or consenting individuals is characterized by sexual impulses, urges or behaviours that are manifestations of a sustained, focused and intense pattern of atypical sexual arousal that is associated with either marked distress or significant risk of injury or death. In contrast, compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control sexual impulses, urges or behaviours, regardless of the focus of sexual arousal. If an individual with paraphilic disorder involving solitary behaviour or consenting individuals is able to exercise some degree of control over the behavioural expressions of the arousal pattern, an additional diagnosis of compulsive sexual behavioural disorder is generally not warranted.

Boundary with disorders due to substance use

Episodes of sexual behaviour that are atypical for the individual may occur during substance intoxication. Such episodes may not be a manifestation of a sustained, focused and intense sexual arousal pattern. At the same time, some individuals with paraphilic disorders may use substances with the intention of engaging atypical sexual behaviour that *does* reflect an underlying paraphilic arousal pattern. A diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals may be assigned together with a disorder due to substance use if the diagnostic requirements for both are met.

Boundary with other mental disorders in the context of rejection or feared rejection

If distress related to rejection or feared rejection of the arousal pattern by others has reached a point that presenting symptoms meet the diagnostic requirements for another mental disorder (e.g. adjustment disorder, a depressive disorder, an anxiety or fear-related disorder), that diagnosis should be assigned rather than paraphilic disorder involving solitary behaviour or consenting individuals.

Boundary with other mental disorders in the context of sexual behaviours that are atypical for the individual

Sexual behaviours that are atypical for the individual that do not reflect an underlying, persistent pattern of sexual arousal may occur in the context of some mental disorders, such as bipolar type I disorder during manic or mixed episodes, or dementia. If the sexual behaviours involved do not reflect an underlying, persistent pattern of sexual arousal, a diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals should not be assigned.

Boundary with gender incongruence of adolescence or adulthood

Individuals who have a focused and intense pattern of sexual arousal involving cross-dressing might qualify for the diagnosis of paraphilic disorder involving solitary behaviour or consenting individuals if they are markedly distressed by having this pattern of arousal. A history of sexual excitement in association with cross-dressing can sometimes be a feature of gender incongruence that develops in adolescence or adulthood, but such a history is not a sufficient basis for diagnosing paraphilic disorder involving solitary behaviour or consenting individuals.

6D3Z Paraphilic disorder, unspecified

Factitious disorders

Factitious disorders are characterized by feigning, falsifying or intentionally inducing or aggravating medical, psychological or behavioural signs and symptoms or injury in oneself or in another person associated with identified deception. A pre-existing disorder or disease may be present, but the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms. Individuals with factitious disorders seek treatment or otherwise present themselves or another person as ill, injured or impaired based on the feigned, falsified or self-induced signs, symptoms or injuries. The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g. obtaining disability payments or evading criminal prosecution). This is in contrast to malingering, in which clear external rewards or incentives motivate the behaviour.

Factitious disorders include:

6D50 Factitious disorder imposed on self

6D51 Factitious disorder imposed on another

6D5Z Factitious disorder, unspecified.

6D50 Factitious disorder imposed on self

Essential (required) features

- The presentation is characterized by feigning, falsifying or intentionally inducing medical, psychological or behavioural signs and symptoms or injury associated with identified deception. If a pre-existing disorder or disease is present, the individual intentionally aggravates existing symptoms or falsifies or induces additional symptoms.
- The individual seeks treatment or otherwise presents themselves as ill, injured or impaired based on the feigned, falsified or self-induced signs, symptoms or injuries.
- The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g. obtaining disability payments or evading criminal prosecution).
- The behaviour is not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder).

Additional clinical features

- Examples of behaviours involved in factitious disorder imposed on self include falsely reporting or simulating episodes of neurological or mental symptoms (e.g. seizures, hearing voices); manipulating laboratory tests to falsely indicate an abnormality (e.g. adding sugar to urine); falsifying past or current medical records to indicate an illness; ingesting a substance (e.g. warfarin) to produce an abnormal laboratory result or illness; and physically injuring or intentionally inducing illness in oneself (e.g. intentional exposure to infectious or toxic agents).
- The simulation of illness, injury or impairment and the insistence and intensity of its presentation may be so convincing and persistent that repeated investigations or even surgeries are performed, sometimes at many different hospitals or clinics, in spite of repeated negative or inconclusive findings.
- The motivation for the behaviour is presumed to be psychological. Factitious disorder imposed on self can be understood as a disorder of illness behaviour and adoption of the sick role. Seeking attention, especially from health-care providers as a part of the sick role, often appears to be a motivation for the behaviour.
- There is evidence that factitious disorder imposed on self in adulthood may be associated with being the victim of factitious disorder imposed on another in childhood.

Boundary normality (threshold)

- Some individuals with medical conditions may exaggerate their symptoms in order to gain more attention from medical professionals, family members or the community, or to gain access to additional treatment. A diagnosis of factitious disorder imposed on self should only be considered if there is evidence that the person is feigning, falsifying or intentionally inducing or aggravating the symptoms.

Course features

- The typical age at identification of individuals with factitious disorder imposed on self is 30–40 years, but at the time of first assessment it is often revealed that the disorder has been present without being detected for many years.
- There is some evidence that individuals with factitious disorder imposed on self typically progress from less to more extreme modes of medical deception, and from an episodic to a chronic pattern.
- Individuals with factitious disorder imposed on self often do not provide accurate histories or access to their past medical records. As a result, systematic data regarding the onset and development of their factitious illness behaviour and its long-term outcomes are extremely limited.

Developmental presentations

- Factitious disorder imposed on self can occur in adolescents, and has been identified in young children.
- Among children and adolescents, commonly reported falsified or induced conditions include fevers, ketoacidosis, rashes and infections. Methods of fabrication may include false reporting of symptoms, self-bruising, ingestion of harmful substances and self-injections.

Sex- and/or gender-related features

- A substantial majority of individuals identified with factitious disorder imposed on self are female.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with bodily distress disorder and hypochondriasis (health anxiety disorder)

Individuals with bodily distress disorder or hypochondriasis may exaggerate their symptoms at times to ensure that their care is prioritized or taken seriously, as a part of excessive attention and treatment-seeking related to somatic symptoms. However, unlike factitious disorder imposed on self, there is no evidence that the person is feigning, falsifying or intentionally inducing or aggravating the symptoms.

Boundary with dissociative neurological symptom disorder

In dissociative neurological symptom disorder, symptoms (e.g. seizures, paralysis) are presented that are not consistent with neurological findings or other pathophysiology. In contrast to factitious disorder imposed on self, however, individuals with dissociative neurological symptom disorder do not feign, falsify or intentionally induce their symptoms.

Boundary with malingering

In malingering, individuals also deceptively report, feign or induce symptoms in order to falsify or exaggerate the severity of an illness. However, in malingering, primary external incentives are considered to be motivating the behaviour. The most common external motives for malingering include evading criminal prosecution, obtaining psychoactive medications (e.g. opioids), avoiding military conscription or dangerous military duty, and attempting to obtain sickness or disability benefits or improvements in living conditions such as housing. Malingering is not considered a mental disorder and is classified in Chapter 24 on factors influencing health status or contact with health services. In factitious disorder imposed on self, the deceptive behaviour is not solely motivated by obvious external incentives.

Boundary with other forms of self-injurious behaviour

Individuals who exhibit self-injurious behaviour, often in the context of another mental disorder, may intentionally provide false information to examiners regarding either the self-induced nature of the injuries or the presence of suicidal ideation or intent. The deception in these cases is typically intended to minimize rather than exaggerate the extent to which the individual is viewed as ill, injured or impaired.

6D51 Factitious disorder imposed on another

Essential (required) features

- The presentation is characterized by feigning, falsifying or intentionally inducing medical, psychological or behavioural signs and symptoms or injury in another person – most commonly a child dependent – associated with identified deception. If a pre-existing disorder or disease is present in the other person, the individual intentionally exaggerates or aggravates existing symptoms, or falsifies or induces additional symptoms.
- The individual seeks treatment for the other person or otherwise presents them as ill, injured or impaired based on the feigned, falsified or induced signs, symptoms or injuries.
- The deceptive behaviour is not solely motivated by obvious external rewards or incentives (e.g. obtaining disability payments or avoiding criminal prosecution for child or elder abuse).
- The behaviour is not better accounted for by another mental disorder (e.g. schizophrenia or another primary psychotic disorder).

Note: the diagnosis of factitious disorder imposed on another is assigned to the individual who is feigning, falsifying or inducing the symptoms in another person, not to the person who is presented as having the symptoms. Occasionally, the individual induces or falsifies symptoms in a pet rather than in another person.

Additional clinical features

- The range of behaviours involved in factitious disorder imposed on another is similar to those in factitious disorder imposed on self, and includes reporting episodes of neurological or mental symptoms in the other person; manipulating laboratory tests to falsely indicate an abnormality (e.g. adding sugar to urine); falsifying past or current medical records to indicate an illness; administering a substance (e.g. warfarin) to produce an abnormal laboratory result or illness; and physically injuring or intentionally inducing illness in the other person (e.g. intentional exposure to infectious or toxic agents).
- The simulation or induction of illness or injury in factitious disorder imposed on another may be quite dramatic, resulting in numerous medical investigations and interventions in spite of negative or inconclusive findings.
- The person presented as ill, injured or impaired would in many cases be considered to be a victim of physical or psychological maltreatment (i.e. abuse), which should be classified

separately using the appropriate code from Chapter 23 on external causes of morbidity or mortality.

- There is evidence that a significant proportion of perpetrators of factitious disorder imposed on another have a history of factitious disorder imposed on self.

Boundary with normality (threshold)

- Some individuals whose loved ones have medical conditions may exaggerate the reports of symptoms to medical professionals in order to get their loved one's care prioritized, or to access additional treatments they perceive as necessary or potentially beneficial. Factitious disorder imposed on another should only be considered if there is evidence that the person is feigning, falsifying or intentionally inducing or aggravating the symptoms of the other person.

Sex- and/or gender-related features

- The most common presentation of factitious disorder imposed on another is a mother who fabricates symptoms in one or more of her children.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with motivated deception related to physical abuse

Caregivers who lie about the cause of abuse injuries in their dependents (e.g. claiming that an injury was the result of an "accident" rather than child or elder abuse) solely in order to avoid criminal prosecution or the intervention of child protective services should not be diagnosed with factitious disorder imposed on another. The diagnosis of factitious disorder imposed on another requires a clinical judgement that there are additional motivations for the deceptive behaviour, such as obtaining the attention and admiration of health-care providers.

Boundary with mental disorders with psychotic symptoms

Individuals with other mental disorders (e.g. schizophrenia and other primary psychotic disorders, mood disorders) may sometimes harm others, including their children, in response to a command hallucination or a delusion, or as part of a suicide attempt. In such cases, there is typically no evidence of deception associated with the harmful behaviour other than to avoid criminal prosecution for child abuse or other intervention (e.g. removal of a child by protective services).

6D5Z Factitious disorder, unspecified

Neurocognitive disorders

Neurocognitive disorders are characterized by primary clinical deficits in neurocognitive functioning that are acquired rather than developmental. Neurocognitive functioning specifically refers to neurologically based cognitive skills and abilities believed to be directly related to brain functioning, including but not limited to attention/concentration, memory, language, visual spatial/perceptual skills, processing speed and executive functioning (e.g. problem solving, judgement).

Neurocognitive disorders represent a decline from a previously attained level of functioning. This grouping does not include disorders characterized by deficits in neurocognitive functioning that are present from birth or that typically arise during the developmental period, which are classified in the grouping of neurodevelopmental disorders. Although cognitive deficits are present in many mental disorders (e.g. schizophrenia, bipolar disorders), only disorders whose core features are neurocognitive are included in the neurocognitive disorders grouping.

Neurocognitive disorders include the following:

6D70 Delirium

6D70.0 Delirium due to disease classified elsewhere
6D70.1 Delirium due to psychoactive substances, including medications

Note: The following subcategories are cross-listed from disorders due to substance use:

6C40.5 Alcohol-induced delirium
6C41.5 Cannabis-induced delirium
6C42.5 Synthetic cannabinoid-induced delirium
6C43.5 Opioid-induced delirium
6C44.5 Sedative, hypnotic or anxiolytic-induced delirium
6C45.5 Cocaine-induced delirium
6C46.5 Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone
6C47.5 Synthetic cathinone-induced delirium
6C49.4 Hallucinogen-induced delirium
6C4B.5 Volatile inhalant-induced delirium
6C4C.5 MDMA or related drug-induced delirium, including MDA
6C4D.4 Dissociative drug-induced delirium, including ketamine and PCP
6C4E.5 Delirium induced by other specified psychoactive substance, including medications
6C4F.5 Delirium induced by multiple specified psychoactive substances, including medications

6C4G.5 Delirium induced by unknown or unspecified psychoactive substances
6D70.2 Delirium due to multiple etiological factors
6D70.Y Delirium, other specified cause
6D70.Z Delirium, unknown or unspecified cause

6D71 Mild neurocognitive disorder

6D72 Amnestic disorder

6D72.0 Amnestic disorder due to diseases classified elsewhere
6D72.1 Amnestic disorder due to psychoactive substances, including medications
- 6D72.10 Amnestic disorder due to use of alcohol
- 6D72.11 Amnestic disorder due to use of sedatives, hypnotics or anxiolytics
- 6D72.12 Amnestic disorder due to other specified psychoactive substance, including medications
- 6D72.13 Amnestic disorder due to use of volatile inhalants

6D72.Y Amnestic disorder, other specified cause
6D72.Z Amnestic disorder, unknown or unspecified cause

6D80 Dementia due to Alzheimer disease

6D80.0 Dementia due to Alzheimer disease with early onset
6D80.1 Dementia due to Alzheimer disease with late onset
6D80.2 Alzheimer disease dementia, mixed type, with cerebrovascular disease
6D80.3 Alzheimer disease dementia, mixed type, with other nonvascular etiologies
6D80.Z Dementia due to Alzheimer disease, onset unknown or unspecified

6D81 Dementia due to cerebrovascular disease

6D82 Dementia due to Lewy body disease

6D63 Frontotemporal dementia

6D84 Dementia due to psychoactive substances, including medications

6D84.0 Dementia due to use of alcohol
6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics
6D84.2 Dementia due to use of volatile inhalants
6D84.Y Dementia due to use of other specified psychoactive substance

6D85 Dementia due to diseases classified elsewhere

6D85.0 Dementia due to Parkinson disease
6D85.1 Dementia due to Huntington disease
6D85.2 Dementia due to exposure to heavy metals and other toxins
6D85.3 Dementia due to HIV
6D85.4 Dementia due to multiple sclerosis
6D85.5 Dementia due to prion disease
6D85.6 Dementia due to normal-pressure hydrocephalus
6D85.7 Dementia due to injury to the head
6D85.8 Dementia due to pellagra
6D85.9 Dementia due to Down syndrome
6D85.Y Dementia due to other specified disease classified elsewhere

6D8Y Dementia, other specified cause

6D8Z Dementia, unknown or unspecified cause

6E0Y Other specified neurocognitive disorder

6E0Z Neurocognitive disorder, unspecified.

Additional categories for specific symptoms are provided in the grouping MB21 Symptoms, signs or clinical findings involving cognition in Chapter 21 on symptoms, signs or clinical findings, not elsewhere classified. These may be used to provide additional detail regarding a particular presentation or to describe more transient symptoms (e.g. symptoms that are closely tied to an underlying medical condition that are not a specific focus of intervention).

In cases where the underlying pathology and etiology for neurocognitive disorders can be determined, the diagnosis corresponding to the identified etiology should also be assigned.

General cultural considerations for neurocognitive disorders

- Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible, as in the following examples.
  - Test performance may be affected by cultural biases (e.g. references in test items to terminology or objects not common to a culture) and limitations of translation and adaptation.
  - In evaluating functioning in important everyday skills, the expectations of the individual's culture and social environment should be considered.
  - Similarly, when determining the presence of perceived or observed cognitive change, it is important to consider cultural variations that may exist regarding expectations or tolerance for cognitive change. For example, some degree of memory loss or cognitive impairment might be seen as normal in some family or social systems, and may not be fully recognized when existing support systems are available to compensate.

  - Linguistic and cultural proficiency must also be considered when interpreting test results, in terms of both whether the individual understood the instructions and the impact on test performance.

- When standardized testing is utilized for determination of neurocognitive impairment, it should be appropriately developed and normed for the population of which the individual being tested is a member. Where appropriately normed and standardized tests are not available, assessment of the essential features of these disorders requires greater reliance on clinical judgement based on appropriate evidence and other quantified clinical assessment.

General considerations related to sex and/or gender for neurocognitive disorders

- Performance on clinical assessment or standardized neuropsychological/cognitive testing may differ according to sex and/or gender-related factors. When clinical assessment or standardized neuropsychological/cognitive testing is utilized for determination of memory or other neurocognitive impairment, sex and/or gender-related factors should be considered and accounted for when possible.

6D70 Delirium

Delirium includes the following subcategories:

6D70.0 Delirium due to disease classified elsewhere
6D70.1 Delirium due to psychoactive substances, including medications
6D70.2 Delirium due to multiple etiological factors
6D70.Y Delirium, other specified cause
6D70.Z Delirium, unknown or unspecified cause.

General diagnostic requirements for delirium

Essential (required) features

- A disturbance of attention, orientation and awareness developing within a short period of time (e.g. within hours or days), typically presenting as significant confusion or global neurocognitive impairment, with transient symptoms that may fluctuate depending on the underlying causal condition or etiology, is required for diagnosis.
- The disturbance represents a change from the individual's baseline functioning.

- Delirium may be caused by the direct physiological effects of a medical condition not classified under mental, behavioural and neurodevelopmental disorders, by the direct physiological effects of a substance or medication – including withdrawal – or by multiple or unknown etiological factors.
- The symptoms are not better accounted for by a pre-existing or evolving neurocognitive disorder (e.g. amnestic disorder, mild neurocognitive disorder, dementia) or by another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder).
- When a substance or medication is present, the symptoms are in excess of those typical of substance intoxication or substance withdrawal for that substance, although delirium can occur as a complication of intoxication or withdrawal states (see 6D70.1 Delirium due to psychoactive substances, including medications, below).

Additional clinical features

- In delirium, cognition is typically impaired in a global manner, such that multiple areas of neurocognitive functioning are impaired upon assessment.
- Delirium may include impaired perception, which can manifest as illusions (i.e. misinterpretations of sensory inputs), delusions or hallucinations.
- Delirium often includes disturbance of emotion, including anxiety symptoms, depressed mood, irritability, fear, anger, euphoria or apathy.
- Behavioural symptoms may be present (e.g. agitation, restlessness, impulsivity). A disturbance of the sleep-wake cycle, including reduced arousal of acute onset or total sleep loss followed by reversal of the sleep-wake cycle, may also be present.
- The presence of a pre-existing neurocognitive disorder can increase the risk of delirium and complicate its course.

Boundary with normality (threshold)

- Normal ageing is typically associated with some degree of cognitive change. Delirium is differentiated from age-related cognitive changes by the sudden onset of symptoms (e.g. within hours or days), the presence of significant confusion and/or global neurocognitive impairment, and the transient and typically fluctuating symptom presentation.

Course features

- Onset of symptoms is typically sudden (e.g. within hours or days), with a transient and/or fluctuating course.
- Symptoms are generally expected to remit with treatment of the underlying etiology or elimination of the causative substance from the body.

Developmental presentations

- Susceptibility to delirium in infancy and childhood may be greater than in early and middle adulthood.
- In childhood, delirium may be related to febrile illnesses and certain medications (e.g. anticholinergics).
- Older individuals are especially susceptible to delirium compared with younger adults.

Culture-related features

- Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible.
- When standardized neuropsychological/cognitive testing is utilized for determination of neurocognitive impairment, performance should be measured with appropriately normed, standardized tests. In situations where appropriately normed and standardized tests are not available, assessment of neurocognitive functioning requires greater reliance on clinical judgement. (See the section on general cultural considerations for neurocognitive disorders above for additional information and examples.)

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with dementia

Delirium is differentiated from other neurocognitive disorders in that the former is characterized by global neurocognitive impairment and confusion that have a precipitous onset, are transient, and fluctuate depending on the underlying causal condition or etiology. Dementia is more typically characterized by impairment in specific neurocognitive abilities, and is often progressive and more gradual in onset. Individuals with dementia are at increased risk of delirium, and those who develop acute disturbances in attention, orientation and awareness should be assigned an additional diagnosis of delirium and evaluated to determine its specific etiology.

Boundary with neurocognitive impairment associated with acquired or traumatic brain injuries

Delirium is differentiated from an acute confusional or agitated state related to acquired or traumatic brain injuries by the absence of evidence of a preceding neurological injury or event (e.g. traumatic brain injury, cerebral haemorrhage, stroke).

Boundary with transient global amnesia

Unlike delirium, transient global amnesia is characterized by the presence of isolated memory impairment alongside intact functioning in other cognitive areas (e.g. naming skills, self-identification). Although both disorders may present with memory impairment, delirium is frequently characterized by additional symptoms, including significant confusion, global neurocognitive impairment, and behavioural and emotional disturbance (e.g. hallucinations, agitation).

Boundary with factitious disorder and malingering

In factitious disorder and malingering, the neurocognitive symptoms characteristic of delirium are consciously feigned. Feigned or induced symptoms may be – although they are not necessarily – atypical in pattern, magnitude or course, or may be medically implausible. Individuals with factitious disorder feign neurocognitive symptoms in order to seek attention, especially from health-care providers, and to assume the sick role. Malingering is characterized by intentional feigning of neurocognitive impairment for obvious external incentives (e.g. disability payments).

Boundary with schizophrenia and other primary psychotic disorder

Delirium accompanied by hallucinations and/or delusions is differentiated from schizophrenia and other primary psychotic disorders by the absence of other characteristics of these disorders, and by symptoms that are transient and fluctuate depending on the underlying causal condition or etiology.

Boundary with dissociative amnesia

Selective memory deficits are present in dissociative amnesia, and may be accompanied by confusion about identity if dissociative fugue is present. Dissociative amnesia is not characterized by disturbances in attention or awareness, general confusion or global neurocognitive impairment, which are features of delirium.

6D70.0 Delirium due to disease classified elsewhere

Essential (required) features

- All diagnostic requirements for delirium are met.
- There is evidence from the history, physical examination or laboratory findings that the neurocognitive disturbance is caused by the direct physiological consequences of a medical condition. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing delirium.
  - The course of the delirium (e.g. onset, trajectory of symptoms, response to treatment) is consistent with causation by the medical condition.

Note: when delirium is due to a disease or condition classified elsewhere, the diagnostic code corresponding to that disease or condition should be assigned along with delirium due to disease classified elsewhere. If the delirium is attributed to multiple medical conditions or to a medical condition and a substance or medication, the category 6D70.2 Delirium due to multiple etiological factors should be used instead. This may include medications being used to manage the medical condition.

Potentially explanatory medical conditions (examples)

- Certain infectious or parasitic diseases (e.g. meningitis, viral hepatitis, sepsis)
- Diseases of liver (e.g. chronic hepatic failure, hepatic encephalopathy)
- Diseases of the circulatory system (e.g. acute myocardial infarction)
- Diseases of the nervous system (e.g. cerebral ischaemic stroke, epilepsy or seizures, hypertensive encephalopathy)
- Diseases of the urinary system (e.g. kidney failure, urinary tract infection)
- Endocrine disorders (e.g. diabetic ketoacidosis, hyperthyroidism, hypothyroidism)
- Metabolic disorders (e.g. acidosis, disorders of urea cycle metabolism, hypoglycaemia, hypomagnesaemia, hypo-osmolality, hyponatraemia)
- Neoplasms of the brain or central nervous system
- Nutritional disorders (e.g. vitamin B_1, B_3 or B_{12} deficiency)

6D70.1 Delirium due to psychoactive substances, including medications

Essential (required) features

- All diagnostic requirements for delirium are met.
- There is evidence from history, physical examination or laboratory findings that the neurocognitive disturbance is caused by the direct physiological consequences of use of a substance or medication. This judgement depends on establishing the following.
  - The substance and the amount and duration of its use or withdrawal from the substance is known to be capable of producing delirium.
  - The course of the delirium (e.g. onset, trajectory of symptoms, eventual remission with elimination of the substance from the body) is consistent with causation by the substance.
- The duration or severity of the symptoms is substantially in excess of the characteristic syndrome of substance intoxication or substance withdrawal due to the specified substance.

Note: each specific substance that has been identified as contributing to the delirium should be classified using the appropriate substance-specific category. If one or more of the categories appearing below is diagnosed, a separate diagnosis of delirium due to psychoactive substances, including medications, should not be assigned.

6C40.5	Alcohol-induced delirium (see Table 6.16, p. 484, for a description of delirium associated with alcohol withdrawal)
6C41.5	Cannabis-induced delirium
6C42.5	Synthetic cannabinoid-induced delirium
6C43.5	Opioid-induced delirium
6C44.5	Sedative, hypnotic or anxiolytic-induced delirium (see Table 6.16, p. 484, for a description of delirium associated with sedative, hypnotic or anxiolytic withdrawal)

6C45.5	Cocaine-induced delirium
6C46.5	Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone
6C47.5	Synthetic cathinone-induced delirium
6C49.4	Hallucinogen-induced delirium
6C4B.5	Volatile inhalant-induced delirium
6C4C.5	MDMA or related drug-induced delirium, including MDA
6C4D.4	Dissociative drug-induced delirium, including ketamine and PCP
6C4E.5	Delirium induced by other specified psychoactive substance, including medications
6C4F.5	Delirium induced by multiple specified psychoactive substances, including medications
6C4G.5	Delirium induced by unknown or unspecified psychoactive substance

A diagnosis corresponding to the pattern of use of the relevant psychoactive substance (e.g. episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use, substance dependence) may also be assigned.

If the delirium is attributed to a substance or medication together with one or more medical conditions, the category 6D70.2 Delirium due to multiple etiological factors should be used instead. This may include medications being used to manage the medical condition.

6D70.2 Delirium due to multiple etiological factors

Essential (required) features

- All diagnostic requirements for delirium are met.
- There is evidence from the history, physical examination or laboratory findings that the delirium is caused by either:
  - the direct physiological consequences of multiple diseases classified elsewhere; or
  - one or more diseases classified elsewhere and the direct effects of a substance or medication on the central nervous system.
- This judgement depends on establishing the following.
  - The medical conditions are known to be capable of producing delirium.
  - If applicable, the amount and duration of use of the substance or withdrawal from the substance is known to be capable of producing delirium.
  - If applicable, the duration or severity of the symptoms is substantially in excess of the characteristic syndrome of substance intoxication or substance withdrawal due to the specified substance.
  - The course of the delirium (e.g. onset, trajectory of symptoms, eventual remission with elimination of the substance from the body) is consistent with causation by the medical conditions and, if applicable, the substance.

Note: when delirium is related to one or more diseases or conditions classified elsewhere, the diagnostic code corresponding to those diseases or conditions should be assigned along with delirium due to multiple etiological factors.

6D70.Y Delirium, other specified cause

Essential (required) features

- All diagnostic requirements for delirium are met.
- The delirium is presumed to be attributable to an identified cause that is not adequately captured by any of the other available delirium categories.
- This judgement depends on establishing the following:
  - The specified cause is known to be capable of producing delirium.
  - The course of the delirium (e.g. onset, trajectory of symptoms, response to treatment) is consistent with the specified cause.

Note: the ICD-11 diagnosis corresponding to the presumed etiology should also be assigned.

6D70.Z Delirium, unknown or unspecified cause

6D71 Mild neurocognitive disorder

Essential (required) features

- The presence of mild impairment in one more or cognitive domains (e.g. attention, executive function, language, memory, perceptual-motor abilities, social cognition) relative to expectations for age and general premorbid level of neurocognitive functioning is required for diagnosis.
- Impairment represents a decline from the individual's previous level of functioning.
- Neurocognitive impairment is not severe enough to interfere significantly with an individual's ability to perform activities related to personal, family, social, educational and/or occupational functioning or other important functional areas.
- Evidence of mild neurocognitive impairment is based on:
  - information obtained from the individual, an informant or clinical observation;
  - objective evidence of impairment as demonstrated by standardized neuropsychological/cognitive testing or, in its absence, another quantified clinical assessment.
- Neurocognitive impairment is not attributable to normal ageing.
- Neurocognitive impairment may be attributable to an underlying acquired disease of the nervous system, a trauma, an infection or other disease process affecting the brain, use of specific substances or medications, nutritional deficiency or exposure to toxins, or the etiology may be undetermined.

- The symptoms are not better explained by another neurocognitive disorder, substance intoxication or substance withdrawal, or another mental disorder (e.g. attention deficit hyperactivity disorder or other neurodevelopmental disorder, schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder).

Note: cases referred to elsewhere as "mild cognitive impairment" are referred to in ICD-11 as "mild neurocognitive disorder". When mild neurocognitive disorder is due to a disease, condition or injury classified elsewhere (including disorders due to substance use), the diagnostic code corresponding to that disease, condition or injury should assigned in addition to mild neurocognitive disorder. When the etiological condition is unknown, the diagnosis **8A2Z Disorders with neurocognitive impairment as a major feature, unspecified,** may be assigned in addition to mild neurocognitive disorder.

Potentially explanatory medical conditions (examples)

Mild neurocognitive disorder may be caused by any of the specified causes of dementia (see specific types of dementia, p. 621). In addition, mild neurocognitive disorder may be caused by:

- anaemias or other erythrocyte disorders;
- certain infectious or parasitic diseases (e.g. meningitis);
- diseases of the circulatory system (e.g. coronary atherosclerosis);
- diseases of the nervous system (e.g. cerebral palsy, epilepsy or seizures, hypertensive encephalopathy, hypoxic-ischaemic encephalopathy);
- endocrine diseases (e.g. diabetes mellitus, hypothyroidism);
- intracranial injury;
- metabolic disorders (e.g. hypo-osmolality or hyponatraemia);
- neoplasms of the brain or central nervous system;
- nutritional disorders (e.g. vitamin B_{12} deficiency).

Additional clinical features

- Mild declines in complex activities may be typically present (e.g. using transportation, meal preparation), while basic activities of daily living (e.g. dressing, bathing) are preserved. The individual may engage in compensatory strategies to maintain independence in everyday functioning.
- Behavioural and psychological symptoms are commonly associated with mild neurocognitive disorder (e.g. depressed mood, sleep disturbance, anxiety).

Boundary with normality (threshold)

- Normal ageing is typically associated with some degree of cognitive change. A diagnosis of mild neurocognitive disorder does not apply if performance is consistent with expectations for the individual's age, based on age-related norms for performance on standardized assessment.

Course features

- The course of neurocognitive impairment in mild neurocognitive disorder may be static or progressive, or may resolve or improve depending on the specific etiology and available treatment options.
- In some cases, mild neurocognitive disorder may represent an early presentation of an underlying disease of the nervous system that may later meet the diagnostic requirements for dementia.

Developmental presentations

- Mild neurocognitive disorder can occur at any point across the lifespan, with risk and prevalence depending on the underlying etiology. Overall risk of mild neurocognitive disorder increases with age because of the increased prevalence of possible causal conditions.

Culture-related features

- Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible.
- When standardized neuropsychological/cognitive testing is utilized for determination of neurocognitive impairment, performance should be measured with appropriately normed, standardized tests. In situations where appropriately normed and standardized tests are not available, assessment of neurocognitive functioning requires greater reliance on clinical judgement. (See the section on general cultural considerations for neurocognitive disorders above for additional information and examples.)

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with delirium

Delirium is characterized by a disturbance of attention, orientation and awareness, with transient symptoms that may fluctuate depending on the underlying causal condition or etiology. Delirium typically presents with significant confusion or global neurocognitive impairment, in contrast to mild neurocognitive disorder, in which there is mild impairment in one or more cognitive domains that does not interfere significantly with functioning.

Boundary with amnestic disorder

Amnestic disorder is characterized by prominent memory impairment relative to expectations for age and general premorbid level of neurocognitive functioning that is severe enough to result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning, in the absence of other significant neurocognitive impairment. While specific presentations of mild neurocognitive disorder may primarily affect memory, the memory impairment is not severe enough to interfere significantly with functioning in everyday skills and tasks.

Boundary with dementia

Dementia is characterized by marked impairment in two or more cognitive domains that is severe enough to cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Neurocognitive deficits in mild neurocognitive disorder may be in similar areas, but are not severe enough to cause significant impairment in functioning.

Boundary with mild cognitive symptoms in other mental disorders

Mild cognitive symptoms may be a characteristic or associated feature of a wide range of mental disorders (e.g. attention deficit hyperactivity disorder, schizophrenia and other primary psychotic disorders, mood disorders, anxiety and fear-related disorders, post-traumatic stress disorder, dissociative disorders). If the neurocognitive impairment is better explained by another mental disorder, an additional diagnosis of mild neurocognitive disorder should not be assigned.

Boundary with sleep-wake disorders

Memory and other neurocognitive impairment is frequently reported by individuals with sleep disturbance or sleep-wake disorders, such as insomnia and sleep apnoea. If the neurocognitive impairment is better explained by a sleep-wake disorder, an additional diagnosis of mild neurocognitive disorder should not be assigned.

6D72 Amnestic disorder

Amnestic disorder includes the following subcategories:

6D72.0 Amnestic disorder due to diseases classified elsewhere

6D72.1 Amnestic disorder due to psychoactive substances, including medications

6D72.10 Amnestic disorder due to use of alcohol

6D72.11 Amnestic disorder due to use of sedatives, hypnotics or anxiolytics

6D72.12 Amnestic disorder due to other specific psychoactive substances, including medications

6D72.13 Amnestic disorder due to use of volatile inhalants

6D72.Y Amnestic disorder, other specified cause

6D72.Z Amnestic disorder, unknown or unspecified cause.

General diagnostic requirements for amnestic disorder

Essential (required) features

- Prominent memory impairment relative to expectations for age and general level of premorbid neurocognitive functioning, in the absence of other significant neurocognitive impairment, is required for diagnosis.
- The memory impairment represents a marked decline from previous levels of functioning.
- The memory impairment is characterized by reduced ability to acquire, learn and/or retain new information.
- Evidence of memory impairment is based on:
  - information obtained from the individual, an informant or clinical observation;
  - substantial impairment in memory performance as demonstrated by standardized neuropsychological/cognitive testing or, in its absence, another quantified clinical assessment.
- The symptoms are not better accounted for by disturbance of consciousness, altered mental status, transient global amnesia (i.e. memory impairment lasting no more than 48 hours, with most cases resolving within 6 hours), delirium, dementia, substance intoxication, substance withdrawal or another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. In mild cases, if functioning is maintained, it is only through significant additional effort (e.g. compensatory strategies).

Note: when amnestic disorder is due to a disease, condition or injury classified elsewhere (including disorders due to substance use), the diagnostic code corresponding to that disease, condition or injury should assigned along with amnestic disorder. When the etiological condition is unknown, the diagnosis 8A2Z Disorders with neurocognitive impairment as a major feature, unspecified, may be assigned in addition to amnestic disorder.

Additional clinical features

- Amnestic disorder may or may not include the inability to recall previously learned information. Recent memory is typically more impaired than remote memory, and the ability to recall a limited amount of information immediately is usually relatively preserved.
- Standardized neuropsychological/cognitive testing or quantified clinical assessment may be needed to determine the magnitude and pattern of other neurocognitive impairments, and to differentiate amnestic disorder from other neurocognitive disorders (e.g. dementia).
- Subjective reports by the affected individual of impairments in learning, memory or recall do not always correspond to objective or measurable impairment in these areas because of potential alteration in the individual's awareness, misperceptions of abilities, or misattribution of the cause/source of symptoms or problems. Similarly, it is possible that individuals with altered awareness of deficits may not acknowledge or report memory impairments that are present.
- If standardized neuropsychological/cognitive testing or quantified clinical assessment is not available, the symptom code MB21.1Z Amnesia, unspecified, may be used provisionally until a quantified assessment can be conducted.

Boundary with normality (threshold)

- Normal ageing is typically associated with some degree of memory change. A diagnosis of amnestic disorder does not apply if performance is consistent with expectations for the individual's age, based on age-related norms for performance on standardized assessment.
- When memory difficulties consistent with normal ageing are present and clinically relevant, the symptom code MB21.0 Age-associated cognitive decline may be used.

Course features

- Onset of symptoms can be sudden (e.g. when due to stroke or trauma) or gradual (e.g. when due to psychoactive substances or nutritional deficiencies).

- Symptoms may be relatively stable over time or progressive, depending on the underlying causal condition or etiology. In some cases, symptoms may improve over time, depending on the specific etiology and available treatment options.
- When memory impairment worsens progressively over time (e.g. due to an underlying disease of the nervous system), amnestic disorder may represent a prodrome for dementia.

Culture-related features

- Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible.
- When standardized neuropsychological/cognitive testing is utilized for determination of neurocognitive impairment, performance should be measured with appropriately normed, standardized tests. In situations where appropriately normed and standardized tests are not available, assessment of neurocognitive functioning requires greater reliance on clinical judgement. (See the section on general cultural considerations for neurocognitive disorders above for additional information and examples.)

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with delirium

Although delirium often includes memory impairment, it is differentiated from amnestic disorder by the presence of disturbances in attention, orientation and awareness, and significant confusion or global neurocognitive impairment, in contrast to the specific and prominent memory impairment seen in amnestic disorder.

Boundary with mild neurocognitive disorder

Unlike amnestic disorder, mild neurocognitive disorder is characterized by a *mild* level of neurocognitive decline, with little or no impairment in functioning of everyday skills and tasks. In mild neurocognitive disorder, symptoms are not typically restricted to memory impairment.

Boundary with dementia

Amnestic disorder is characterized by prominent memory impairment relative to expectations for age and general level of premorbid neurocognitive functioning, in the absence of other significant neurocognitive impairment. In contrast, dementia is characterized by impairment in two or more cognitive domains, which frequently but not always include memory.

Boundary with dissociative amnesia

Amnestic disorder is characterized by selective and prominent impairment in the ability to learn and remember new information, usually with relative sparing of memory for previously learned

information and past events and experiences. In contrast, dissociative amnesia is characterized by inability to recall important autobiographical memories – typically of recent traumatic or stressful events – that is inconsistent with ordinary forgetting, and is often preceded by an emotional stressor, conflict or trauma.

Boundary with memory symptoms in other mental disorders

Memory impairment may be a presenting feature other mental disorders (e.g. schizophrenia, mood disorders, post-traumatic stress disorder, dissociative disorders). If the memory impairment is better explained by another mental disorder, an additional diagnosis of amnestic disorder should not be assigned.

Boundary with transient global amnesia

In transient global amnesia the memory impairment is temporary (i.e. lasting no longer than 48 hours, with most cases resolving within 6 hours) whereas in amnestic disorder memory impairment is persistent, although in some cases it may improve with treatment, depending on the etiology.

6D72.0 Amnestic disorder due to diseases classified elsewhere

Essential (required) features

- All diagnostic requirements for amnestic disorder are met.
- There is evidence from history, physical examination or laboratory findings that symptoms are caused by the direct physiological consequences of a medical condition (e.g. a disease of the nervous system, a traumatic brain injury, an infection, a tumour, another disease process affecting areas of the brain involved in memory). This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing memory impairment.
  - The course of the memory impairment (e.g. onset, trajectory of symptoms, response to treatment) is consistent with causation by the medical condition.

Note: when amnestic disorder is due to a disease, condition or injury classified elsewhere (including disorders due to substance use), the diagnostic code corresponding to that disease, condition or injury should assigned along with amnestic disorder. When the etiological condition is unknown, the diagnosis 8A2Z Disorders with neurocognitive impairment as a major feature, unspecified, may be assigned in addition to amnestic disorder.

Potentially explanatory medical conditions (examples)

- Anaemias or other erythrocyte disorders
- Certain infectious or parasitic diseases (e.g. meningitis)
- Diseases of the nervous system (e.g. cerebral ischaemic stroke, cerebral palsy, epilepsy or seizures, hypoxic-ischaemic encephalopathy)

- Endocrine diseases (e.g. hypothyroidism)
- Intracranial injury
- Metabolic disorders (e.g. hypo-osmolality or hyponatraemia)
- Neoplasms of the brain or central nervous system
- Nutritional disorders (e.g. vitamin B_1 or B_{12} deficiency)

6D72.1 Amnestic disorder due to psychoactive substances, including medications

Essential (required) features

- All diagnostic requirements for amnestic disorder are met.
- There is evidence from history, physical examination or laboratory findings that the disturbance is caused by the direct physiological consequences of use of a substance or medication that persists beyond the usual duration of substance intoxication or substance withdrawal. This judgement depends on establishing the following.
  - The substance or medication and the amount and duration of its use is known to be capable of producing the memory disturbance.
  - The course of the memory disturbance (e.g. onset, trajectory of symptoms, response to treatment) is consistent with causation by the substance or medication.

Note: if the specific substance inducing the amnestic disorder has been identified, it should be classified using the appropriate subcategory:

6D72.10	Amnestic disorder due to use of alcohol
6D72.11	Amnestic disorder due to use of sedatives, hypnotics or anxiolytics
6D72.12	Amnestic disorder due to other specific psychoactive substances, including medications
6D72.13	Amnestic disorder due to use of volatile inhalants.

A diagnosis corresponding to the pattern of use of the relevant psychoactive substance (e.g. episode of harmful psychoactive substance use, harmful pattern of psychoactive substance use, substance dependence) may also be assigned.

Note: the order of the categories under 6D72.1 Amnestic disorder due to psychoactive substances, including medications, is different from that of other parallel entities (e.g. substance-induced dementia, below), in which the "other specified" category is listed last. This difference is not meaningful; the categories should be used in the same way.

6D72.Y Amnestic disorder, other specified cause

Essential (required) features

- All diagnostic requirements for amnestic disorder are met.
- The amnestic disorder is presumed to be attributable to an identified cause that is not adequately captured by any of the other available amnestic disorder categories.

- This judgement depends on establishing the following.
  - The specified cause is known to be capable of producing amnestic disorder.
  - The course of the amnestic disorder (e.g. onset, trajectory of symptoms, response to treatment) is consistent with the specified cause.

6D72.Z Amnestic disorder, unknown or unspecified cause

Dementia

Dementia includes the following categories:

6D80 Dementia due to Alzheimer disease
- 6D80.0 Dementia due to Alzheimer disease with early onset
- 6D80.1 Dementia due to Alzheimer disease with late onset
- 6D80.2 Alzheimer disease dementia, mixed type, with cerebrovascular disease
- 6D80.3 Alzheimer disease dementia, mixed type, with other nonvascular etiologies
- 6D80.Z Dementia due to Alzheimer disease, onset unknown or unspecified

6D81 Dementia due to cerebrovascular disease
6D82 Dementia due to Lewy body disease
6D83 Frontotemporal dementia
6D84 Dementia due to psychoactive substances, including medications
- 6D84.0 Dementia due to use of alcohol
- 6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics
- 6D84.2 Dementia due to use of volatile inhalants
- 6D84.Y Dementia due to other specified psychoactive substance

6D85 Dementia due to diseases classified elsewhere
- 6D85.0 Dementia due to Parkinson disease
- 6D85.1 Dementia due to Huntington disease
- 6D85.2 Dementia due to exposure to heavy metals and other toxins
- 6D85.3 Dementia due to HIV
- 6D85.4 Dementia due to multiple sclerosis
- 6D85.5 Dementia due to prion disease
- 6D85.6 Dementia due to normal-pressure hydrocephalus
- 6D85.7 Dementia due to injury to the head
- 6D85.8 Dementia due to pellagra
- 6D85.9 Dementia due to Down syndrome
- 6D85.Y Dementia due to other specified disease classified elsewhere

6D8Y Dementia, other specified cause
6D8Z Dementia, unknown or unspecified cause.

This section begins by providing the general diagnostic requirements for dementia, which are applicable to all forms of dementia. Next, additional information is provided about the diagnostic requirements for each of the specific types of dementia.

Each of the dementia categories may be described as mild, moderate or severe. The general CDDR for dementia also provide guidance on applying each level of the severity specifier:

XS5W	Mild
XS0T	Moderate
XS25	Severe

Specifiers are also provided for behavioural or psychological disturbances in dementia that may be used when these are severe enough to represent a focus of clinical intervention. These specifiers are also described below as part of the general CDDR for dementia. As many behavioural or psychological disturbances specifiers may be applied as necessary to describe the current clinical picture. These specifiers may be applied to all dementia categories. They include:

6D86.0 Psychotic symptoms in dementia
6D86.1 Mood symptoms in dementia
6D86.2 Anxiety symptoms in dementia
6D86.3 Apathy in dementia
6D86.4 Agitation or aggression in dementia
6D86.5 Disinhibition in dementia
6D86.6 Wandering in dementia
6D86.Y Other specified behavioural or psychological disturbance in dementia
6D86.Z Behavioural or psychological disturbance in dementia, unspecified.

General diagnostic requirements for dementia

Essential (required) features

- Marked impairment in two or more cognitive domains relative to the level expected given the individual's age and general premorbid level of neurocognitive functioning, which represents a decline from the individual's previous level of functioning, is required for diagnosis.
- Memory impairment is present in most forms of dementia, but neurocognitive impairment is not restricted to memory and may be present in other cognitive domains such as executive functioning, attention, language, social cognition and judgement, psychomotor speed, and visuoperceptual or visuospatial functioning.
- Evidence of neurocognitive impairment is based on:
  - information obtained from the individual, an informant or clinical observation;
  - substantial impairment in neurocognitive performance as demonstrated by standardized neuropsychological/cognitive testing or, in its absence, another quantified clinical assessment.
- Behavioural changes (e.g. changes in personality, disinhibition, agitation, irritability) may also be present and, in some forms of dementia, may be the presenting symptom.

Additional clinical features for dementia

- Symptom course may provide information about the etiology of dementia (see the descriptions below of dementia due to specific etiologies). Most dementias are progressive (e.g. dementia due to Alzheimer disease, dementia due to Lewy body disease, frontotemporal dementia), whereas other forms are reversible (e.g. dementia related to nutritional or metabolic abnormalities), stable (e.g. some cases of dementia due to cerebrovascular disease) or rapidly progressing (e.g. dementia due to prion disease).

Boundary with normality (threshold) for dementia

- Normal ageing is typically associated with some degree of cognitive change. Dementia is differentiated from normal ageing by the severity or magnitude of neurocognitive impairment relative to expectations for age, and by functional impairment in everyday skills and tasks. Deviation from normal ageing can be determined by standardized assessment using appropriately normed measures. When cognitive difficulties consistent with normal ageing are present and clinically relevant, the symptom code MB21.0 Age-associated cognitive decline may be used.

Course features for dementia

- Onset and course of symptoms varies considerably by dementia etiology. (See additional information below regarding symptom onset and course for dementia due to specific etiologies.)

Developmental presentations for dementia

- Dementia in children or young adults is rare, and often caused by neuronal ceroid lipofuscinoses, a group of lysosomal storage disorders.
- Dementia due to Down syndrome occurs in about 50% or more of individuals with Down syndrome, and typically emerges after the fourth decade of life.
- Risk of dementia increases in older adulthood.

Culture-related features for dementia

- Performance during clinical assessment may vary according to cultural and/or linguistic factors. When assessing impairment in neurocognitive functioning and activities of daily living, cultural and linguistic factors should be considered and accounted for when possible.
- When standardized neuropsychological/cognitive testing is utilized for determination of neurocognitive impairment, performance should be measured with appropriately normed, standardized tests. In situations where appropriately normed and standardized tests are not available, assessment of neurocognitive functioning requires greater reliance on clinical judgement. (See the section on general cultural considerations for neurocognitive disorders above for additional information and examples.)

Boundaries with other disorders and conditions (differential diagnosis) for dementia

Boundary with delirium

Delirium is differentiated from dementia in that delirium is characterized by global neurocognitive impairment and confusion that have a precipitous onset, are transient, and fluctuate depending on the underlying causal condition or etiology. Dementia is more typically characterized by impairment in specific cognitive skills, and is often progressive and more gradual in onset. Individuals with dementia are at increased risk of delirium, and those who develop acute disturbances in attention, orientation and awareness should be assigned an additional diagnosis of delirium and evaluated to determine its specific etiology.

Boundary with mild neurocognitive disorder

Dementia is characterized by marked impairment in two or more cognitive domains that is severe enough to cause significant impairment in personal, family, social, educational, occupational or other important areas of functioning. Neurocognitive deficits in mild neurocognitive disorder may be in similar cognitive domains, but are not severe enough to cause significant impairment in functioning.

Boundary with amnestic disorder

Amnestic disorder is characterized by prominent memory impairment relative to expectations for age and general level of premorbid neurocognitive functioning, in the absence of other significant neurocognitive impairment. In contrast, dementia is characterized by impairment in two or more cognitive domains, which often but not invariably include memory.

Boundary with disorders of intellectual development

Disorders of intellectual development are characterized by significant limitations in both intellectual functioning and adaptive behaviour, with onset during the developmental period. By convention, cases that meet the diagnostic requirements for disorders of intellectual development are diagnosed as such unless the neurocognitive impairments are known to be caused by an etiology that is specifically associated with dementia, in which case the dementia diagnosis

may be considered. The disorders can co-occur, and some adults with disorders of intellectual development are at greater and earlier risk of developing dementia. For example, individuals with Down syndrome who exhibit a marked decline in adaptive behaviour functioning should be evaluated for the emergence of dementia. In cases in which the diagnostic requirements for both a disorder of intellectual development and dementia are met and describe non-redundant aspects of the clinical presentation, both diagnoses may be assigned.

Boundary with mood disorders

Cognitive concerns and mild measurable cognitive deficits may occur in the context of mood disorders. These typically improve with appropriate treatment of the corresponding mood disorder, whereas in dementia neurocognitive impairment is not significantly affected by treatment of the mood disorder. Standardized assessment or quantified clinical assessment may be helpful in identifying the presence and objective severity of neurocognitive impairment, which may not correspond with an individual's subjective cognitive complaints.

Boundary with factitious disorder and malingering

In factitious disorder and malingering, the neurocognitive symptoms characteristic of dementia are consciously feigned. Feigned symptoms may be – although they are not necessarily – atypical in pattern, magnitude or course, or may be medically implausible. Individuals with factitious disorder feign neurocognitive symptoms in order to seek attention, especially from health-care providers, and to assume the sick role. Malingering is characterized by intentional feigning of neurocognitive impairment for obvious external incentives (e.g. disability payments).

Boundary with neurocognitive symptoms in other mental disorders

Neurocognitive symptoms may be a characteristic or associated feature of a wide range of mental disorders (e.g. schizophrenia and other primary psychotic disorders, post-traumatic stress disorder, dissociative disorders). If the neurocognitive impairment is better explained by another mental disorder, an additional diagnosis of dementia should not be assigned.

Specific types of dementia

6D80 Dementia due to Alzheimer disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying 8A20 Alzheimer disease, based on quantified clinical assessment or standardized neuropsychological/cognitive testing, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.

Additional clinical features

- Early clinical history is typically characterized by gradual onset, progressive memory problems and word-finding difficulties, as well as mild functional impairment. The most common form of Alzheimer disease begins with neuronal impairment in the medial temporal lobes (the brain regions involved in memory formation).
- As Alzheimer disease progresses and affects other brain regions, neurocognitive symptoms worsen.
- Atypical forms of Alzheimer disease are also characterized by progressive neurocognitive and functional impairment, with initial neurocognitive symptoms often corresponding to the brain region initially affected (e.g. visual processing impairment in posterior cortical atrophy).

Note: for all forms of dementia due to Alzheimer disease, the diagnosis 8A20 Alzheimer disease in Chapter 8 on diseases of the nervous system should also be assigned.

6D80.0 Dementia due to Alzheimer disease with early onset

Essential (required) features

- All diagnostic requirements for dementia due to Alzheimer disease are met.
- Neurocognitive, functional and/or behavioural symptoms associated with Alzheimer disease were present prior to the age of 65 years, as evidenced by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.

6D80.1 Dementia due to Alzheimer disease with late onset

Essential (required) features

- All diagnostic requirements for dementia due to Alzheimer disease are met.
- Neurocognitive, functional and/or behavioural symptoms associated with Alzheimer disease were present at or after the age of 65 years, as evidenced by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.

6D80.2 Alzheimer disease dementia, mixed type, with cerebrovascular disease

Essential (required) features

- All diagnostic requirements for dementia due to Alzheimer disease are met.
- Neurocognitive, functional and/or behavioural symptoms of dementia appear to be partially related to co-existing cerebrovascular disease, as demonstrated by neuroimaging, medical tests and/or clinical history of cerebrovascular disease.
- The clinical course of neurocognitive and functional impairment is progressive, and typically characterized by combined impairment in so-called cortical cognitive functions (e.g. memory, language, visuospatial skills) and so-called subcortical cognitive functions (e.g. attention, processing speed, executive/frontal lobe-related functioning).

6D80.3 Alzheimer disease dementia, mixed type, with other nonvascular etiologies

Essential (required) features

- All diagnostic requirements for dementia due to Alzheimer disease are met.
- Neurocognitive, functional and/or behavioural symptoms of dementia appear to be partially related to a known comorbid etiology, as demonstrated by neuroimaging data, genetic testing, medical tests, family history, medical history and/or clinical history.

6D80.Z Dementia due to Alzheimer disease, onset unknown or unspecified

6D81 Dementia due to cerebrovascular disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying cerebrovascular disease, as demonstrated by neuroimaging, medical tests and/or clinical history of cerebrovascular disease.
- The diagnostic requirements for Alzheimer disease dementia, mixed type, with cerebrovascular disease are not met.

Additional clinical features

- Neurocognitive symptoms often follow cerebrovascular compromise. In stroke, the type of neurocognitive impairment varies depending on the brain region in which the stroke occurred. Stroke-related neurocognitive impairment typically begins abruptly after a stroke. Improvement in initial neurocognitive deficits is typically seen, with recovery reaching a plateau over time. Residual neurocognitive deficits often remain chronic over time.
- In contrast, in microvascular events, neurocognitive impairment typically affects so-called subcortical neurocognitive functions (e.g. attention, processing speed, executive/frontal lobe-related functions). If microvascular events are attributed to progressing chronic conditions (e.g. hypertension, diabetes), as is common, the clinical course of neurocognitive impairment may be slowly progressive.

Note: an appropriate diagnosis from the Cerebrovascular diseases grouping in Chapter 8 on diseases of the nervous system should also be assigned.

6D82 Dementia due to Lewy body disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying Lewy body disease, as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.
- Clinical history involves the presence of two or more of the following symptoms:
  - recurrent visual hallucinations (typically well-formed)
  - episodic confusion
  - REM sleep behaviour disorder
  - one or more features of parkinsonism (e.g. resting tremor).

Additional clinical features

- Neurocognitive symptoms are progressive, and often involve relatively greater impairment in visuospatial skills, attention and executive functioning (as opposed to primary memory impairment, as seen in Alzheimer disease).
- Additional clinical features may include repeated falls, syncope, hallucinations in other sensory modalities, delusions and autonomic dysfunction (e.g. constipation, urinary incontinence).

Note: a diagnosis of 8A22 Lewy body disease in Chapter 8 on diseases of the nervous system should also be assigned.

6D83 Frontotemporal dementia

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying frontotemporal disease or atrophy, as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.

Additional clinical features

- Frontotemporal dementia variants include primary progressive aphasia (logopenic, semantic and agrammatic subtypes), behavioural frontotemporal dementia and motoric frontotemporal dementia (corticobasal degeneration, progressive supranuclear palsy and amyotrophic lateral sclerosis).
- Frontotemporal dementia is progressive, with variants identified based on initial symptoms.
  - **Frontotemporal dementia, behavioural variant,** is characterized by personality changes, often including apathy and progressively inappropriate social behaviour. Neurocognitive functioning may be preserved in the early stages, though the progression may later involve deficits in executive functioning (e.g. planning, problem solving), with comparatively intact memory skills.
  - **Frontotemporal dementia, primary progressive aphasia**, is characterized by progressive impairment in language skills, initially in the absence of impairment in other cognitive skills. Subtypes of primary progressive aphasia are often determined based on neuropsychological/cognitive testing, clinical presentation and sometimes neuroimaging, and are characterized by primary deficits in word finding (logopenic subtype), word meaning (semantic subtype) or word production (agrammatic subtype).
  - **Frontotemporal dementia, motoric variant,** involves progressive impairment in motor functioning, sometimes in the context of progressive neurocognitive impairment (typically characterized by impairment in attention, executive functioning and visuospatial skills, with comparatively intact memory skills). Frontotemporal dementia, motoric variant, can include progressive supranuclear palsy (e.g. poor balance, frequent falls, visual impairment from gaze palsy), corticobasal degeneration (e.g. limb apraxia, tripping, rigidity, dystonia) and amyotrophic lateral sclerosis (e.g. muscle weakness, muscle atrophy, fasciculations, spasticity).

Note: a diagnosis of 8A23 Frontotemporal lobar degeneration in Chapter 8 on diseases of the nervous system should also be assigned.

6D84 Dementia due to psychoactive substances, including medications

Essential (required) features

- All diagnostic requirements for dementia are met.
- There is evidence from history, physical examination or laboratory findings that dementia is caused by the direct physiological consequences of use of a substance or medication that persists beyond the usual duration of substance intoxication or withdrawal.
- This judgement depends on establishing the following.
  - The substance or medication and the amount and duration of its use is known to be capable of producing dementia.
  - The course of the dementia (e.g. onset, trajectory of symptoms, response to treatment) is consistent with that caused by the substance or medication.

Note: specific substances are known to be capable of producing dementia. If the specific substance inducing the dementia has been identified, the corresponding diagnostic category should be assigned:

6D84.0 Dementia due to use of alcohol
6D84.1 Dementia due to use of sedatives, hypnotic or anxiolytics
6D84.2 Dementia due to use of volatile inhalants
6D84.Y Dementia due to other specified psychoactive substance.

A diagnosis corresponding to the pattern of use of the relevant psychoactive substance (e.g. harmful pattern of psychoactive substance use, substance dependence) may also be assigned.

6D85 Dementia due to diseases classified elsewhere

The following categories for dementia associated with other diseases or conditions known to cause dementia are available:

6D85.0	Dementia due to Parkinson disease
6D85.1	Dementia due to Huntington disease
6D85.2	Dementia due to exposure to heavy metals and other toxins
6D85.3	Dementia due to HIV
6D85.4	Dementia due to multiple sclerosis
6D85.5	Dementia due to prion disease
6D85.6	Dementia due to normal-pressure hydrocephalus
6D85.7	Dementia due to injury to the head
6D85.8	Dementia due to Pellagra
6D85.9	Dementia due to Down syndrome
6D85.Y	Dementia due to other specified disease classified elsewhere.

6D85.0 Dementia due to Parkinson disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying Parkinson disease, as demonstrated by neuropsychological test data, neuroimaging data, medical tests, family history and/or clinical history.

Additional clinical features

- Dementia due to Parkinson disease develops among individuals with idiopathic Parkinson disease, and is often characterized by impairment in attention, memory, executive and visuospatial functions.
- Behavioural and psychiatric symptoms such as changes in affect, apathy and hallucinations may also be present.
- Onset is insidious and typically occurs 1 year or more after the development of Parkinsonian motor symptoms. The course of dementia often follows that of underlying Parkinson disease (e.g. if Parkinson disease gradually worsens, dementia may gradually worsen).

Note: a diagnosis of 8A00.0 Parkinson disease in Chapter 8 on diseases of the nervous system should also be assigned.

6D85.1 Dementia due to Huntington disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying Huntington disease, as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.

Additional clinical features

- Dementia due to Huntington disease occurs as part of a widespread degeneration of the brain due to a trinucleotide repeat expansion in the HTT gene, which is transmitted through autosomal dominance.

- Onset of symptoms is insidious, typically in the third and fourth decade of life, with gradual and slow progression.
- Initial symptoms typically include impairments in executive functions, with relative sparing of memory, prior to the onset of motor deficits (bradykinesia and chorea) characteristic of Huntington disease.

Note: a diagnosis of 8A01.10 Huntington disease in Chapter 8 on diseases of the nervous system should also be assigned.

6D85.2 Dementia due to exposure to heavy metals and other toxins

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to toxic exposure to specific heavy metals, such as aluminium from dialysis water, lead, mercury or manganese, as demonstrated by neuropsychological test data, neuroimaging data, medical tests and/or clinical history.

Additional clinical features

- The characteristic neurocognitive impairments in dementia due to exposure to heavy metals and other toxins depend on the specific heavy metal or toxin that the individual has been exposed to, but can affect any cognitive domain.
- Onset of symptoms is related to exposure, and progression can be rapid especially with acute exposure.
- In some cases, symptoms are reversible when exposure is identified and ceases.

Note: an appropriate diagnosis from the NE61 Harmful effects of or exposure to noxious substances, chiefly nonmedicinal as to source, not elsewhere classified, grouping in Chapter 22 on injury, poisoning or certain other consequences of external causes should also be assigned.

6D85.3 Dementia due to HIV

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying HIV disease, as demonstrated by neuropsychological test data, neuroimaging data, medical tests and/or clinical history.

Additional clinical features

- Dementia due to HIV may develop during the course of confirmed HIV disease, in the absence of a concurrent illness or condition other than HIV infection that could explain the clinical features.
- Although a variety of patterns of neurocognitive deficits are possible, depending on where the HIV pathogenic processes have occurred, typically deficits follow a subcortical pattern with impairments in executive function, processing speed, attention and learning new information.
- The course of dementia due to HIV, varies and may involve gradual decline in functioning, improvement or resolution of symptoms, or fluctuation in symptoms over time.
- Rapid decline in neurocognitive functioning is rare, with the advent of antiretroviral medications.

Note: an appropriate diagnosis from the Human immunodeficiency virus disease grouping in Chapter 1 on certain infectious or parasitic diseases should also be assigned.

6D85.4 Dementia due to multiple sclerosis

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to the cerebral effects of underlying multiple sclerosis – a demyelinating disease – as demonstrated by neuropsychological test data, neuroimaging data, medical tests and/or clinical history. Cognitive symptoms are not primarily due to associated physiological or functional effects of the underlying disease (e.g. fatigue, motoric limitations).

Additional clinical features

- Onset of symptoms is often insidious, but progression may occur in a stepwise fashion, in accordance with the underlying disease course.
- Neurocognitive impairments vary according to the location of demyelination, but typically include deficits in processing speed, memory, attention and aspects of executive functioning.

Note: a diagnosis of 8A40 Multiple sclerosis in Chapter 8 on diseases of the nervous system should also be assigned.

6D85.5 Dementia due to prion disease

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying human prion disease, as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests and/or clinical history.

Additional clinical features

- Dementia due to prion disease is caused by a group of spongiform encephalopathies resulting from abnormal prion protein accumulation in the brain. These can be sporadic, genetic (caused by mutations in the prion protein gene) or transmissible (acquired from an infected individual).
- Onset is insidious, and progression of symptoms and impairment is rapid, often characterized by neurocognitive deficits, ataxia and motor symptoms (e.g. myoclonus, chorea or dystonia).
- Diagnosis is typically made on the basis of clinical presentation, brain imaging studies, presence of characteristic proteins in spinal fluid, EEG and/or genetic testing.

Note: an appropriate diagnosis from the Human prion diseases grouping in Chapter 8 on diseases of the nervous system should also be assigned.

6D85.6 Dementia due to normal-pressure hydrocephalus

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to underlying normal-pressure hydrocephalus, as demonstrated by neuropsychological test data, neuroimaging data, medical tests and/or clinical history.

Additional clinical features

- Dementia due to normal-pressure hydrocephalus results from excess accumulation of cerebrospinal fluid in the brain as a result of idiopathic, non-obstructive causes, but can also be secondary to haemorrhage, infection or inflammation.
- Progression is gradual but intervention (e.g. shunt) may result in improvement of symptoms, especially if administered early in the course of the condition.
- Typically, neurocognitive impairments include reduced processing speed and deficits in executive functioning and attention. These symptoms are also typically accompanied by gait abnormalities and urinary incontinence.
- Brain imaging to reveal ventricular volume and characterize brain displacement is often necessary to confirm the diagnosis.

Note: a diagnosis of 8D64.04 Normal-pressure hydrocephalus in Chapter 8 on diseases of the nervous system should also be assigned.

6D85.7 Dementia due to injury to the head

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to an injury to the head, as demonstrated by neuropsychological test data, neuroimaging data, medical tests and/or clinical history.

Additional clinical features

- Dementia due to injury to the head is caused by damage inflicted on the tissues of the brain as the direct or indirect result of an external force.
- Trauma to the brain is known to have resulted in loss of consciousness, amnesia, disorientation and confusion, and/or neurological signs.
- The symptoms characteristic of dementia due to injury to the head arise immediately following the trauma or after the individual gains consciousness, and must include persistent cognitive impairments following any recovery of initial cognitive impairment that may be seen in the immediate post-injury period.
- Neurocognitive deficits vary depending on the specific brain areas affected and the severity of the injury, but can include impairments in attention, memory, executive functioning, personality, processing speed, social cognition and language abilities.

Note: a diagnosis of NA07 Intracranial injury or one of its subcategories in Chapter 22 on injury, poisoning or certain other consequences of external causes should also be assigned.

6D85.8 Dementia due to pellagra

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to pellagra, as demonstrated by neuropsychological test data, medical tests and/or clinical history.

Additional clinical features

- Dementia due to pellagra is caused by persistent lack of vitamin B_3 (niacin) or tryptophan either in the diet or due to poor absorption in the gastrointestinal tract due to disease (e.g. Crohn disease) or due to the effects of some medications (e.g. isoniazid).
- Core signs of pellagra include dermatological changes (sensitivity to sunlight, lesions, alopecia and oedema) and diarrhoea.
- With prolonged nutritional deficiency, neurocognitive symptoms that include aggression, motor disturbances (ataxia and restlessness), confusion and weakness may be observed.
- Treatment with nutritional supplementation (e.g. niacin) typically results in reversal of symptoms.

Note: a diagnosis of 5B5C.0 Pellagra in Chapter 5 on endocrine, nutritional or metabolic diseases should also be assigned.

6D85.9 Dementia due to Down syndrome

Essential (required) features

- All diagnostic requirements for dementia are met.
- Dementia is presumed to be attributable to Down syndrome, as demonstrated by neuropsychological test data, genetic testing, medical tests and/or clinical history.

Additional clinical features

- Dementia due to Down syndrome is caused by abnormal increased production and accumulation of amyloid precursor protein (APP), leading to formation of beta-amyloid

plaques and tau tangles. APP gene expression is increased due to its location on chromosome 21, which is abnormally triplicated in Down syndrome. Dementia due to Down syndrome may affect 50% or more of individuals with Down syndrome.

- Neurocognitive deficits and neuropathological features are similar to those observed in Alzheimer disease.
- Onset is typically after the fourth decade of life, and is often accompanied by a gradual decline in functioning.

Note: a diagnosis of LD40.0 Complete trisomy 21 (Down syndrome) in Chapter 20 on developmental abnormalities should also be assigned.

6D85.Y Dementia due to other specified disease classified elsewhere

Essential (required) features

- All diagnostic requirements for dementia are met.
- The dementia is presumed to be attributable to an underlying disease of the nervous system, trauma, infection, tumour or other disease process affecting specific areas of the brain that is listed in ICD-11 but is not adequately captured by any of the other available dementia categories, as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.
- This judgement depends on establishing the following.
  - The specified cause is known to be capable of producing the symptoms.
  - The course of the impairment (e.g. onset, trajectory of symptoms, response to treatment) is consistent with that known to be associated with the specified cause.

Note: the ICD-11 diagnosis corresponding to the presumed etiology should also be assigned.

6D8Y Dementia, other specified cause

Essential (required) features

- All diagnostic requirements for dementia are met.
- The dementia is presumed to be attributable to an identified and specified underlying cause affecting specific areas of the brain that is *not* listed elsewhere in ICD-11 (and is therefore not classifiable using any of the other available dementia categories, including dementia due to other specified disease classified elsewhere), as demonstrated by neuropsychological test data, neuroimaging data, genetic testing, medical tests, family history and/or clinical history.
- This judgement depends on establishing the following.
  - The specified cause is known to be capable of producing the symptoms.
  - The course of the impairment (e.g. onset, trajectory of symptoms, response to treatment) is consistent with that known to be associated with the specified cause.

- The symptoms are not better accounted for by disturbance of consciousness or altered mental status (e.g. due to seizure, traumatic brain injury, stroke or the effects of medication), delirium, substance intoxication, substance withdrawal or another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder).
- The symptoms result in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. In mild cases, if functioning is maintained, it is only through significant additional effort (e.g. compensatory strategies).

6D8Z Dementia, unknown or unspecified cause

Specifier for dementia severity

Severity of dementia can be rated as *mild* (XS5W), *moderate* (XS0T) or *severe* (XS25), according to the degree of neurocognitive and functional impairment, and the capacity for independence in activities of daily living. Severity is rated based on objective clinical examination and information provided by an informant who has sufficient contact with the patient, such as a family member or caregiver.

To indicate severity, the code for the appropriate severity level is appended to the diagnostic code for the type of dementia using an ampersand (&). For example, "6D82&XS0T" is the code for dementia due to Lewy body disease, moderate.

XS5W Mild dementia

Individuals with mild dementia may be able to live independently, but some supervision and/or support is often required. However, individuals with mild dementia can still take part in community or social activities without help, and may appear unimpaired to those who do not know them well. Judgement and problem solving are typically impaired, but social judgement may be preserved, depending on the etiology. The individual may have difficulty making complex decisions, making plans and/or handling finances (e.g. calculating change, paying bills).

XS0T Moderate dementia

Individuals with moderate dementia require support to function outside the home, and only simple household tasks are maintained. Individuals with moderate dementia have difficulties with basic activities of daily living, such as dressing and personal hygiene. Moderate dementia is often characterized by significant memory loss. Judgement and problem solving are typically significantly impaired, and social judgement is often compromised. The individual has increasing difficulty making complex or important decisions, and is often easily confused. The individual may have difficulty communicating with individuals outside the home without caregiver assistance. Socializing is increasingly difficult, as the individual may behave inappropriately (e.g.

in disinhibited or aggressive ways), with associated behaviour changes (e.g. calling out, clinging, wandering, disturbed sleep, hallucinations). The difficulties are often obvious to most individuals who have contact with the individual.

XS25 Severe dementia

Severe dementia is typically characterized by severe memory impairment, but this varies according to the etiology. There is often total disorientation for time and place. The individual is often completely unable to make judgements or solve problems. Individuals may have difficulty understanding what is happening around them. Individuals are fully dependent on others for basic personal care in activities such as for bathing, toileting and feeding. Urinary and faecal incontinence may emerge at this stage.

Specifiers for behavioural or psychological disturbances in dementia

Behavioural and psychological disturbances are common in dementia. Examples of such symptoms include apathy, mood disturbances, hallucinations, delusions, irritability, agitation, aggression and sleep changes. Typically, these symptoms are more frequent and impairing in moderate and severe forms of dementia, although this varies by etiology. Behavioural and psychological disturbances may be present in early stages of dementia (such as in frontotemporal dementia), and may be more prominent than neurocognitive symptoms.

Specifiers for behavioural or psychological disturbances in dementia should be used when, in addition to the neurocognitive and other disturbances characteristic of dementia, the current clinical picture includes behavioural or psychological symptoms that are severe enough to represent a focus of clinical intervention. As many of the following specifiers may be added to the dementia diagnosis as necessary to describe the relevant aspects of the current clinical picture.

6D86.0 Psychotic symptoms in dementia

The current clinical picture includes clinically significant delusions or hallucinations.

6D86.1 Mood symptoms in dementia

The current clinical picture includes clinically significant mood symptoms such as depressed mood, elevated mood or irritable mood.

6D86.2 Anxiety symptoms in dementia

The current clinical picture includes clinically significant symptoms of anxiety or worry.

6D86.3 Apathy in dementia

The current clinical picture includes clinically significant indifference or lack of interest.

6D86.4 Agitation or aggression in dementia

The current clinical picture includes clinically significant excessive psychomotor activity accompanied by increased tension, and/or hostile or violent behaviour.

6D86.5 Disinhibition in dementia

The current clinical picture includes clinically significant lack of restraint manifested in disregard for social conventions, impulsivity and poor risk assessment.

6D86.6 Wandering in dementia

The current clinical picture includes clinically significant wandering that puts the person at risk of harm.

6D86.Y Other specified behavioural or psychological disturbance in dementia

The current clinical picture includes other behavioural or psychological symptoms as a part of the dementia that are severe enough to represent a focus of clinical intervention.

6D86.Z Behavioural or psychological disturbance in dementia, unspecified

6E0Y Other specified neurocognitive disorder

Essential (required) features

The presence of impairment in one more or cognitive domains (e.g. attention, executive function, language, memory, perceptual-motor abilities, social cognition) relative to the level expected given the individual's age and general premorbid level of neurocognitive functioning, and that does not meet the diagnostic requirements for any other neurocognitive disorder, is required for diagnosis.

- The neurocognitive impairment represents a decline from the individual's previous level of functioning.
- Evidence of neurocognitive impairment is based on information obtained from the individual, an informant or clinical observation, and is accompanied by objective evidence of impairment by quantified clinical assessment or standardized neuropsychological/cognitive testing.
- Neurocognitive impairment is not attributable to normal ageing.
- Neurocognitive impairment may be attributable to an underlying acquired disease of the nervous system, a trauma, an infection or other disease process affecting the brain, use of specific substances or medications, nutritional deficiency or exposure to toxins, or the etiology may be undetermined.
- Neurocognitive impairment is not better accounted for by disturbance of consciousness or altered mental status (e.g. due to seizure, traumatic brain injury, stroke or the effects of medication), a neurodevelopmental disorder, substance intoxication, substance withdrawal or another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder).

Note: when the neurocognitive impairment is due to a disease, condition or injury classified elsewhere (including disorders due to substance use), the diagnostic code corresponding to that disease, condition or injury should also be assigned. In the presence of an identified etiological medical condition, if the neurocognitive symptoms are of short duration (e.g. less than 1 month), and it is expected that with treatment of the causal medical condition the neurocognitive symptoms will remit, a diagnosis of secondary neurocognitive syndrome may be assigned rather than other specified neurocognitive disorder.

6E0Z Neurocognitive disorder, unspecified

Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium

Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium are syndromes associated with pregnancy or the puerperium (commencing within about 6 weeks after delivery) that involve significant mental and behavioural features. These diagnoses may be assigned regardless of whether biological factors related to pregnancy, childbirth or the puerperium are known to be etiologically related to the syndrome. If the symptoms meet the diagnostic requirements for another mental disorder, that diagnosis should also be assigned. These diagnoses may be assigned even if the syndrome represents a recurrence or exacerbation of a pre-existing disorder.

Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium include the following:

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms

6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms

6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified.

6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms

Essential (required) features

- Onset of a syndrome involving significant mental and behavioural features occurring during pregnancy or the puerperium (i.e. up to about 6 weeks following delivery) is required for diagnosis.
- The syndrome does not include delusions, hallucinations or other psychotic symptoms.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants).
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Note: if the symptoms meet the diagnostic requirements for a specific mental disorder (e.g. a mood disorder, an anxiety or fear-related disorder, obsessive-compulsive disorder, adjustment disorder), that diagnosis should also be assigned. If the symptoms do not meet the diagnostic requirements for a specific mental disorder, the presentation can be described using codes from the section on mental or behavioural symptoms, signs or clinical findings (p. 677).

Additional clinical features

- This diagnosis may be assigned regardless of whether biological factors related pregnancy, childbirth or the puerperium are known to be etiologically related to the syndrome.
- Common presentations of mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms, include the following.

Depressive symptoms

These may include depressed mood, excessive crying; difficulty bonding with the baby; withdrawing from family and friends; loss of appetite or eating much more than usual; inability to sleep (insomnia) or sleeping too much; overwhelming fatigue or loss of energy; reduced interest and pleasure in usually enjoyable activities, intense irritability and anger; fears of not being a good mother, feelings of worthlessness, shame, guilt or inadequacy; diminished ability to think clearly, concentrate or make decisions; thoughts of harming oneself or the baby.

Anxiety symptoms

These may include excessive worry, general apprehensiveness not restricted to any particular environmental stimulus, phobic responses (e.g. related to dirt or germs) and panic attacks.

Obsessions and compulsions

Obsessions are repetitive and persistent thoughts, images or impulses/urges that are experienced as intrusive and unwanted, and are commonly associated with anxiety. Compulsions are repetitive behaviours or rituals, including repetitive mental acts, that the individual feels driven to perform in response to an obsession. Obsessions and compulsions typically focus on the newborn or unborn infant (e.g. obsessions about the baby getting hurt, contaminated or lost; compulsive rituals involving checking, mental rituals and seeking reassurance). Unwanted sexual obsessions may also be present. There may also be excessive avoidance, such as avoiding bathing or holding the baby, in response to the obsessions.

Boundary with normality (threshold)

- This diagnosis should not be used to describe mild and transient depressive symptoms that do not meet the diagnostic requirements for a depressive episode, which may occur soon after delivery (so-called "postpartum blues" or "baby blues").
- Postpartum depression may be mistaken for baby blues at first, but the signs and symptoms are more intense, last longer, and interfere with functioning, including the ability to care for the baby. If the diagnostic requirements are met for a depressive episode, a diagnosis of single episode depressive disorder or recurrent depressive disorder should also be assigned.
- Worries and fears about the baby during pregnancy and after childbirth and some degree of intrusive thoughts about possible harms are common, and should not be diagnosed as mental and behavioural disorders associated with pregnancy, childbirth or the puerperium unless they are persistent, associated with substantial distress, and interfere with functioning, including the ability to care for the baby.

Boundaries with other disorders and conditions (differential diagnosis)

- This diagnosis may be assigned even if the syndrome represents a recurrence or exacerbation of a pre-existing disorder (e.g. a mood disorder).

6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms

Essential (required) features

- Onset of a syndrome involving significant mental and behavioural features occurring during pregnancy or the puerperium (i.e. up to about 6 weeks following delivery) is required for diagnosis.
- The syndrome includes psychotic symptoms (i.e. delusions, hallucinations or other psychotic symptoms). Depressive and/or manic mood symptoms are also typically present.
- The symptoms are not a manifestation of another medical condition (e.g. a brain tumour), and are not due to the effects of a substance or medication on the central nervous system (e.g. benzodiazepines), including withdrawal effects (e.g. from stimulants).
- The disturbance results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. If functioning is maintained, it is only through significant additional effort.

Note: this diagnosis may be assigned regardless of whether biological factors related to pregnancy, childbirth or the puerperium are known to be etiologically related to the syndrome. If the symptoms meet the diagnostic requirements for a specific mental disorder (e.g. a mood disorder, schizophrenia or another primary psychotic disorder), that diagnosis should also be assigned. If the symptoms do not meet the diagnostic requirements for a specific mental disorder, the presentation can be described using codes from the section on mental or behavioural symptoms, signs or clinical findings (p. 677).

Additional clinical features

- Psychotic symptoms in mental and behavioural disorders associated with pregnancy, childbirth or the puerperium most commonly occur in the context of a depressive, manic or mixed mood episode, in which case a diagnosis of single episode depressive disorder, recurrent depressive disorder or bipolar type I disorder should also be assigned.
- Additional symptoms may include confusion and disorientation, sleep disturbance, excessive energy and agitation, obsessions and compulsions, paranoid ideation and attempts to harm oneself or the baby.

Boundary with normality (threshold)

- Psychotic-like symptoms or unusual subjective experiences may occur in the general population, but these are usually fleeting in nature and do not interfere with functioning, and the person is typically aware that they are illusions. Such phenomena should not be diagnosed as mental and behavioural disorders associated with pregnancy, childbirth or the puerperium.

Boundaries with other disorders and conditions (differential diagnosis)

- This diagnosis may be assigned even if the syndrome represents a recurrence or exacerbation of a pre-existing disorder (e.g. a mood disorder, schizophrenia or another primary psychotic disorder).

6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified

Psychological or behavioural factors affecting disorders and diseases classified elsewhere

6E40 Psychological or behavioural factors affecting disorders and diseases classified elsewhere

Essential (required) features

- Psychological or behavioural factors are present that adversely affect the manifestation, treatment or course of a disorder or disease classified in another ICD-11 chapter in one or more of the following ways.
  - The factors interfere with the treatment of the disorder or disease by affecting treatment adherence or care seeking (e.g. avoidance of needed medical care in an individual with anxiety, non-adherence to a complex treatment regimen in an individual with personality disorder).
  - The factors constitute an additional health risk to the person with the disorder or disease classified elsewhere (e.g. binge eating in a person with diabetes).
  - The factors influence the underlying pathophysiology to precipitate or exacerbate symptoms, or otherwise necessitate medical attention (e.g. stress response causing chest pain in an individual with coronary heart disease or anxiety causing bronchospasm in an individual with asthma).
- The factors increase the risk of suffering, disability or death.
- The factors represent a focus of clinical attention.

Categories describing specific types of factors

- The following categories may be used to describe the specific types of psychological or behavioural factors that adversely affect the manifestation, treatment or course of a disorder or disease classified in another ICD-11 chapter. Multiple categories may be assigned as necessary to describe the clinical presentation.

6E40.0 Mental disorder affecting disorders and diseases classified elsewhere

- The presence of a mental, behavioural or neurodevelopmental disorder that adversely affects the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. a woman with bulimia nervosa and type 1 diabetes mellitus who skips insulin doses as a way to avoid weight gain that would otherwise be caused by her binge eating).

6E40.1 Psychological symptoms affecting disorders and diseases classified elsewhere

- The presence of psychological symptoms that do not meet the diagnostic requirements for a mental, behavioural or neurodevelopmental disorder that adversely affect the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. depressive symptoms interfering with rehabilitation following surgery).

6E40.2 Personality traits or coping style affecting disorders and diseases classified elsewhere

- The presence of personality traits or coping styles that do not meet the diagnostic requirements for a mental, behavioural or neurodevelopmental disorder that adversely affect the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. pathological denial of the need for surgery in a patient with cancer; hostile, pressured behaviour contributing to heart disease).

6E40.3 Maladaptive health behaviours affecting disorders and diseases classified elsewhere

- The presence of maladaptive health behaviours that adversely affect the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. overeating, lack of exercise).

6E40.4 Stress-related physiological response affecting disorders and diseases classified elsewhere

- The presence of stress-related physiological responses that adversely affect the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. stress-related exacerbation of ulcer, hypertension, arrhythmia or tension headache).

6E40.Y Other specified psychological or behavioural factor affecting disorders and diseases classified elsewhere

- The presence of other psychological or behavioural factors that adversely affect the manifestation, treatment or course of a disorder or disease classified in another chapter is required for diagnosis (e.g. interpersonal, cultural, or religious factors).

6E40.Z Psychological or behavioural factor affecting disorders and diseases classified elsewhere, unspecified

Additional clinical features

- The adverse effects can range from acute, with immediate medical consequences (e.g. anxiety precipitating a cardiac arrhythmia), to chronic, occurring over a long period of time (e.g. chronic occupational stress aggravating diabetes). The adverse effects may be time-limited, episodic, or chronic and persistent. The disorders or diseases potentially affected by psychological or behavioural factors include those with clear pathophysiology (e.g. hypertension, HIV infection, coronary disease), functional syndromes (e.g. chronic fatigue syndrome, irritable bowel syndrome, fibromyalgia) and idiopathic symptoms (e.g. dizziness, tinnitus).

Developmental presentations

- Psychological or behavioural factors affecting disorders and diseases classified elsewhere can occur across the lifespan. Particularly with young children, collateral history from parents or school personnel can assist in diagnosis. Some psychological or behavioural factors are more prevalent at particular stages of life (e.g. body-image concerns in adolescents).

Culture-related features

- Differences between cultures may influence psychological or behavioural factors and their effects on other conditions, such as linguistic and verbal communication, explanatory models of illness, health-care practices and delivery, provider-patient relationships, family and gender roles, and attitudes towards pain and death.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with adjustment disorder

Stress associated with having a medical condition can cause psychological or behavioural symptoms that may meet the diagnostic requirements for adjustment disorder – specifically preoccupation with the stressor or its consequences, including excessive worry, recurrent and distressing thoughts about the stressor, or constant rumination about its implications that results in significant impairment in personal, family, social, educational, occupational or other important areas of functioning. In psychological or behavioural factors affecting disorders and diseases classified elsewhere, the causality is in the opposite direction; that is, psychological or behavioural factors adversely affect an existing medical condition. For example, an individual who, in the weeks following a heart attack, develops severe anxiety whenever they leave the house because they are afraid of experiencing cardiac symptoms when no help is available might be appropriately diagnosed as having adjustment disorder. In contrast, an individual with atherosclerotic heart disease who develops chest pain whenever they become anxious would be diagnosed with psychological or behavioural factors affecting disorders and diseases classified elsewhere. In clinical practice, however, psychological factors and a medical condition are often mutually exacerbating, in which case both diagnoses may be assigned if it is clinically useful to do so.

Boundary with hypochondriasis (health anxiety disorder)

Hypochondriasis is characterized by persistent preoccupation with or fear about the possibility of having one or more serious, progressive or life-threatening diseases. The focus of clinical care is the individual's worry about having a disease; in most cases, no serious medical disease is present. In psychological or behavioural factors affecting disorders and diseases classified elsewhere, anxiety may be a relevant psychological factor affecting a medical condition, but the clinical concern is the adverse effects of the anxiety on the manifestations, course or treatment of the medical condition.

Boundary with bodily distress disorder occurring in an individual with an established medical condition

Bodily distress disorder occurring in an individual with an established medical condition is characterized by a combination of distressing bodily symptoms and a degree of attention related to the symptoms that is clearly excessive in relation to the nature and severity of the medical condition. In contrast, in psychological or behavioural factors affecting disorders and diseases classified elsewhere, the psychological or behavioural factors themselves adversely affect the

manifestations, course or treatment of the medical condition. In cases where the excessive attention paid to the bodily symptoms *does* adversely affect the medical condition (e.g. repeated contact with medical professionals that result in medically unwarranted investigative procedures that have made the medical condition worse), both diagnoses may be assigned if it is clinically useful to do so.

Boundary with secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere

In secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere, a medical condition is judged to be causing mental or behavioural symptoms through a direct physiological mechanism. In contrast, in psychological or behavioural factors affecting disorders and diseases classified elsewhere, the psychological or behavioural factors are judged to affect the manifestations, course or treatment of the medical condition. In both cases, there is a temporal relationship between the psychological and behavioural manifestations and the medical condition, but the presumed causal relationship is in the opposite direction in each.

Boundary with other co-occurring mental disorders and medical conditions

Whereas co-occurrence of a mental, behavioural or neurodevelopmental disorder and a medical condition may have an impact on the management of the medical condition (e.g. medications used in the treatment of the mental disorder interacting with medications used to treat the medical condition), psychological or behavioural factors affecting disorders and diseases classified elsewhere would only be diagnosed if the mental disorder itself is having a negative impact on the manifestations, course or treatment of the medical condition.

Boundary with personality difficulty

Personality difficulty refers to pronounced, longstanding personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of personality disorder. In personality difficulty, there are difficulties in the individual's way of experiencing and thinking about the self, others and the world that may be intermittently manifested in maladaptive patterns of cognitive and emotional experience and expression. The stress associated with being diagnosed or living with a serious medical condition is one factor that could potentially precipitate an exacerbation of personality difficulty. The category 6E40.2 Personality traits or coping style affecting disorders and diseases classified elsewhere, on the other hand, would describe the situation in which personality difficulty has an adverse effect on the manifestations, course or treatment of a medical condition. In clinical practice, however, personality difficulty and a medical condition may be mutually exacerbating, in which case both diagnoses may be assigned if it is clinically useful to do so.

Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere

This grouping includes syndromes characterized by the presence of prominent psychological or behavioural symptoms judged to be direct pathophysiological consequences of a medical condition not classified under mental, behavioural and neurodevelopmental disorders, based on evidence from the history, physical examination or laboratory findings. The symptoms are not accounted for by delirium or by another mental disorder, and are not a psychologically mediated response to a severe medical condition (e.g. adjustment disorder or anxiety symptoms in response to being diagnosed with a life-threatening illness). In the absence of evidence of a physiological link between the medical condition and the psychological or behavioural symptoms, a diagnosis of a secondary mental or behavioural syndrome is typically not warranted.

Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere include the following:

6E60 Secondary neurodevelopmental syndrome

- 6E60.0 Secondary speech or language syndrome
- 6E60.Y Other specified secondary neurodevelopmental syndrome
- 6E60.Z Secondary neurodevelopmental syndrome, unspecified

6E61 Secondary psychotic syndrome

- 6E61.0 Secondary psychotic syndrome, with hallucinations
- 6E61.1 Secondary psychotic syndrome, with delusions
- 6E61.2 Secondary psychotic syndrome, with hallucinations and delusions
- 6E61.3 Secondary psychotic syndrome, with unspecified symptoms

6E62 Secondary mood syndrome

- 6E62.0 Secondary mood syndrome, with depressive symptoms
- 6E62.1 Secondary mood syndrome, with manic symptoms
- 6E62.2 Secondary mood syndrome, with mixed symptoms
- 6E62.3 Secondary mood syndrome, with unspecified symptoms

6E63 Secondary anxiety syndrome

6E64	Secondary obsessive-compulsive or related syndrome
6E65	Secondary dissociative syndrome
6E66	Secondary impulse control syndrome
6E67	Secondary neurocognitive syndrome
6E68	Secondary personality change
6E69	Secondary catatonia syndrome
6E6Y	Other specified secondary mental or behavioural syndrome
6E6Z	Secondary mental or behavioural syndrome, unspecified.

6E60 Secondary neurodevelopmental syndrome

Secondary neurodevelopmental syndromes involve significant neurodevelopmental features that do not fulfil the diagnostic requirements of any of the specific neurodevelopmental disorders that are judged to be a direct pathophysiological consequence of a medical condition not classified under mental and behavioural disorders, based on evidence from the history, physical examination or laboratory findings. The appropriate diagnostic subcategory (see below) should be used depending on whether the difficulties are related to speech or language functions or to other areas.

6E60.0 Secondary speech or language syndrome

Essential (required) features

- The presence of significant difficulties in the acquisition and execution of specific speech or language functions (e.g. errors of pronunciation, articulation or phonology), that arise during the developmental period and persist substantially beyond the expected age, is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition with onset during the prenatal or developmental period, based on evidence from history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of developmental difficulties (e.g. onset, remission, response of the neurodevelopmental symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.

  - The symptoms are not better accounted for by a primary neurodevelopmental disorder (e.g. a developmental speech and language disorder, a disorder of intellectual development).
- The symptoms are a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with developmental speech and language disorders

In developmental speech and language disorders (e.g. developmental speech sound disorder, developmental speech fluency disorder, developmental language disorder), the individual's ability to understand or produce speech and language or to use language in context for the purposes of communication is markedly below what would be expected given the individual's age and level of intellectual functioning. However, if the symptoms meet the diagnostic requirements of developmental speech and language disorders and are judged to be the direct pathophysiological consequence of a medical condition with onset during the prenatal or developmental period, a diagnosis of secondary speech or language syndrome should be assigned instead.

Boundary with disorders of intellectual development

Individuals with a disorder of intellectual development may exhibit impaired speech production. If speech production difficulties require separate clinical attention in the context of a disorder of intellectual development that is judged to be due to a medical condition, an additional diagnosis of a secondary speech or language syndrome may be assigned.

Boundary with selective mutism

Selective mutism is characterized by consistent selectivity in speaking, such that a child demonstrates adequate speech production in specific situations (typically at home), but predictably fails to speak in others (typically at school). Selective mutism can occur in the presence of secondary speech or language syndrome, and both diagnoses may be assigned if warranted.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing speech or language syndromes include:

- diseases of the nervous system (e.g. brain injury, cerebral palsy, encephalopathy, epilepsy or seizures, myasthenia gravis, stroke);
- certain infectious or parasitic diseases (e.g. encephalitis, meningitis);
- developmental anomalies (e.g. Joubert syndrome, cleft palate, deafness);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage).

6E60.Y Other specified secondary neurodevelopmental syndrome

Essential (required) features

Note: presentations that meet the diagnostic requirements of disorders of intellectual development, autism spectrum disorder or stereotyped movement disorder and are judged to be the direct pathophysiological consequence of a medical condition are not diagnosed as secondary neurodevelopmental syndrome because, by convention, these conditions are diagnosed regardless of whether or not they are caused by a medical condition classified elsewhere.

- The presence of significant difficulties arising during the developmental period in the acquisition and execution of specific intellectual, motor coordination or social functions that do not fulfil the diagnostic requirements of disorders of intellectual development, autism spectrum disorder or stereotyped movement disorder, and that persist substantially beyond the expected age, is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition with onset during the developmental period, based on evidence from history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of developmental difficulties (e.g. onset, remission, response of the neurodevelopmental symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by a neurodevelopmental disorder (e.g. a disorder of intellectual development, autism spectrum disorder, developmental motor coordination disorder) or the effects of a medication or substance.
- The symptoms are a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with dementia with onset during the developmental period

Difficulties in the acquisition or execution of specific intellectual or social functions with onset during the developmental period (i.e. prior to the age of 18 years) that represent a decline from a previous level of functioning could be diagnosed as dementia if all diagnostic requirements for dementia are met and the impairments are known to be caused by an etiology that is specifically associated with dementia. Otherwise, if the impairments are known to be due to a medical condition and diagnostic requirements for another neurodevelopmental disorder (e.g. a disorder of intellectual development) are not met, a diagnosis of other specified secondary neurodevelopmental disorder should be considered.

Boundary with disorders of intellectual development or autism spectrum disorder

If the symptoms meet the diagnostic requirements of disorders of intellectual development or autism spectrum disorder and are judged to be the direct pathophysiological consequence of a medical condition with onset during the prenatal or developmental period (e.g. fragile X syndrome), both disorder of intellectual development or autism spectrum disorder and the underlying medical condition should be diagnosed, and a diagnosis of other specified secondary neurodevelopmental syndrome should not be assigned. However, if the diagnostic requirements of a disorder of intellectual development or autism spectrum disorder are not fully met (e.g. limitations in intellectual functioning are present without limitations in adaptive functioning), and the symptoms are attributed to a medical condition with onset during the prenatal or developmental period, a diagnosis of other specified secondary neurodevelopmental syndrome may be assigned.

Boundary with developmental motor coordination disorder

In developmental motor coordination disorder, individuals exhibit significant delays in the acquisition of gross and fine motor skills during the developmental period, and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness or inaccuracy of motor performance. If the difficulties with motor coordination are solely attributable to a disease of nervous system (e.g. cerebral palsy, muscular dystrophy), a disease of the musculoskeletal system or connective tissue, a sensory impairment (especially severe visual impairment) or joint hypermobility, a diagnosis of other specified secondary neurodevelopmental syndrome should be assigned rather than developmental motor coordination disorder.

Boundary with stereotyped movement disorder

Stereotyped movement disorder is a neurodevelopmental disorder that is characterized bythe presence of persistent voluntary, repetitive, stereotyped movements (e.g. body rocking, head banging) that result in significant interference with the ability to engage in normal daily activities or result in severe bodily injury. Stereotyped movement disorder is diagnosed even if it is judged to be caused by a medical condition classified elsewhere, and a diagnosis of other specified secondary neurodevelopmental syndrome is not assigned.

Boundary with other neurodevelopmental disorders

The diagnosis of secondary neurodevelopmental disorder should be assigned instead of other neurodevelopmental disorders when the symptoms are judged to be due to an underlying medical condition. (This does not apply to disorders of intellectual development, autism spectrum disorder or stereotyped movement disorder.)

Boundary with developmental difficulties caused by substances or medications, including withdrawal effects

When establishing a diagnosis of other specified secondary neurodevelopmental syndrome, it is important to rule out the possibility that a medication or substance is causing difficulties in the acquisition or execution of specific intellectual, motor or social functions instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause developmental difficulties at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the developmental difficulties should be established (i.e. the developmental difficulties began after administration of the medication).

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing long-lasting intellectual impairment, poor social functioning, learning difficulties and disruptions in attentional processes include:

- diseases of the nervous system (e.g. acquired epileptic aphasia (Landau-Kleffner syndrome), autoimmune encephalitis, encephalopathy);
- developmental anomalies (e.g. Rett syndrome);
- diseases of the visual system (e.g. congenital blindness, vision impairment);
- endocrine, nutritional or metabolic diseases (e.g. diabetes mellitus, hyper- or hypothyroidism, Lesch-Nyhan syndrome, lysosomal diseases such as neuronal ceroid, lipofuscinosis or sphingolipidosis, mucolipidosis, phenylketonuria);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage);
- neoplasms (e.g. neoplasms of brain or meninges).

Brain disorders and general medical conditions that have been shown to be capable of producing long-lasting movement dysfunction or motor impairment include:

- diseases of the nervous system (e.g. cerebral palsy, Huntington disease, muscular dystrophy, Parkinson disease, tardive dyskinesia);
- developmental anomalies (e.g. Ehlers-Danlos syndrome, Rett syndrome);
- endocrine, nutritional or metabolic diseases (e.g. Lesch-Nyhan syndrome).

6E60.Z Secondary neurodevelopmental syndrome, unspecified

6E61 Secondary psychotic syndrome

Essential (required) features

- The presence of prominent hallucinations and/or delusions is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the hallucinations and/or delusions (e.g. onset, remission, response of the psychotic symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.

- The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

6E61.0 Secondary psychotic syndrome, with hallucinations

Essential (required) features

- All diagnostic requirements for secondary psychotic syndrome are met.
- The presentation is characterized by prominent hallucinations without prominent delusions.

6E61.1 Secondary psychotic syndrome, with delusions

Essential (required) features

- All diagnostic requirements for secondary psychotic syndrome are met.
- The presentation is characterized by prominent delusions without prominent hallucinations.

6E61.2 Secondary psychotic syndrome, with hallucinations and delusions

Essential (required) features

- All diagnostic requirements for secondary psychotic syndrome are met.
- The presentation is characterized by both prominent hallucinations and prominent delusions.

6E61.3 Secondary psychotic syndrome, with unspecified symptoms

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with schizophrenia and other primary psychotic disorders

Determining whether psychotic symptoms are due to a medical condition as opposed to manifestations of a primary mental disorder is often difficult because the clinical presentations may be similar. Establishing the presence of a potentially explanatory medical condition that can cause hallucinations or delusions and the temporal relationship between the medical condition and the psychotic symptoms is critical in diagnosing secondary psychotic syndrome. A list of medical conditions that have been reported to cause psychotic symptoms is included below (p. 659), but the strength of the association varies according to the medical condition. Secondary psychotic syndrome is often characterized by clinical features that would be atypical for a primary psychotic disorder such as later age of onset, rapid occurrence of clouding of consciousness, and accompanying cognitive, neurological or medical symptoms. In secondary psychotic syndrome, disorganized thinking (formal thought disorder) is not typically present, delusions are more often simple and fragmented, and hallucinations are more often visual, tactile, olfactory or gustatory rather than auditory.

Boundary with psychotic symptoms that are precipitated by the stress of being diagnosed with a medical condition

Depending on the nature of the medical condition (e.g. a life-threatening type of cancer, a potentially fatal infection) or its onset (e.g. a heart attack, a stroke, a severe injury), being diagnosed with a severe medical condition can be experienced as a traumatic event, which could trigger the development of psychotic symptoms (e.g. hallucinations and delusions) in susceptible individuals (e.g. individuals with a pre-existing psychotic disorder, a dissociative disorder or a personality disorder). If the psychotic symptoms are part of the presentation of a diagnosable mental disorder that is judged to be precipitated or exacerbated by the stress of being diagnosed or coping with a medical condition, the appropriate mental disorder (e.g. acute and transient psychotic disorder, post-traumatic stress disorder, recurrent depressive disorder) should be diagnosed rather than secondary psychotic syndrome.

Boundary with delirium due to disease classified elsewhere

Hallucinations or delusions can occur in the context of delirium due to disease classified elsewhere. Delirium is characterized by disturbed attention (i.e. reduced ability to direct, focus, sustain and shift attention) and awareness (i.e. reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day, accompanied by other cognitive impairments such as memory deficit, disorientation or impairment in language, visuospatial ability or perception. Disturbed attention and awareness and severe cognitive impairment are not features of secondary psychotic syndrome. If the psychotic symptoms are judged to be better explained by delirium due to disease classified elsewhere, an additional diagnosis of secondary psychotic syndrome is not warranted.

Boundary with dementia

Hallucinations or delusions can occur in the context of dementia, which is characterized by a decline from a previous level of cognitive functioning with impairment in two or more cognitive domains (e.g. memory, executive functions, attention, language, social cognition and judgement, psychomotor speed, visuoperceptual or visuospatial abilities). In contrast, secondary psychotic syndrome is not accompanied by marked cognitive impairment. The presence of hallucinations or delusions in the context of dementia can be recorded using the *psychotic symptoms in dementia* specifier. If the psychotic symptoms are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary psychotic syndrome is not warranted.

Boundary with psychotic symptoms caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary psychotic syndrome, it is important to rule out the possibility that a medication or substance is causing the hallucinations or delusions instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause psychotic symptoms at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the psychotic symptoms should be established (i.e. the psychotic symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and psychotic symptoms who are also using a psychoactive substance known to cause hallucinations or delusions, in the context of either intoxication or withdrawal (e.g. visual hallucinations during sedative, hypnotic or anxiolytic withdrawal; paranoid delusions during cocaine intoxication). In such cases, if the intensity or duration of the psychotic symptoms is substantially in excess of psychotic-like disturbances of perception, cognition or behaviour that are characteristic of the substance-specific intoxication or withdrawal syndromes, then substance-induced psychotic disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing psychotic syndromes include:

- diseases of the nervous system (e.g. encephalitis, encephalopathy, genetic prion disease, intracerebral haemorrhage, Lewy body disease, migraine, movement disorders such as Huntington disease or Friedreich ataxia, multiple sclerosis, seizures, stroke);
- certain infectious or parasitic diseases (e.g. neurosyphilis);
- diseases of the immune system (e.g. systemic lupus erythematosus);
- endocrine, nutritional or metabolic diseases (e.g. hyper- and hypoadrenalism, hyper- and hypoparathyroidism, hyper- and hypothyroidism, hypo-osmolality or hyponatraemia, hypoglycaemia, porphyrias, vitamin B_1 or vitamin B_{12} deficiency, Wilson disease);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage, injury of optic or acoustic nerve);
- neoplasms (e.g. neoplasms of brain or meninges).

6E62 Secondary mood syndrome

Essential (required) features

- The presence of prominent depressive, manic or mixed mood symptoms is required for diagnosis.

- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the mood symptoms (e.g. onset, remission, response of the mood symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. a depressive disorder, bipolar type I or bipolar type II disorder, cyclothymic disorder, catatonia) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

6E62.0 Secondary mood syndrome, with depressive symptoms

Essential (required) features

- All diagnostic requirements for secondary mood syndrome are met.
- The presentation is characterized by prominent depressive symptoms without prominent manic symptoms.

6E62.1 Secondary mood syndrome, with manic symptoms

Essential (required) features

- All diagnostic requirements for secondary mood syndrome are met.
- The presentation is characterized by prominent manic symptoms without prominent depressive symptoms.

6E62.2 Secondary mood syndrome, with mixed symptoms

Essential (required) features

- All diagnostic requirements for secondary mood syndrome are met.
- The presentation is characterized by both prominent depressive and prominent manic symptoms.

6E62.3 Secondary mood syndrome, with unspecified symptoms

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with mood disorders

Determining whether mood symptoms are due to a medical condition as opposed to manifestations of a primary mental disorder is often difficult because the clinical presentations may be similar. Establishing the presence of a potentially explanatory medical condition that can cause mood symptoms and the temporal relationship between the medical condition and the mood symptoms is critical in diagnosing secondary mood syndrome. If the clinical features are atypical for mood disorders (e.g. atypical age of onset or course, absence of family history), secondary mood syndrome is more likely.

Boundary with mood symptoms that are precipitated by the stress of being diagnosed with a medical condition

Depending on the nature of the medical condition (e.g. a life-threatening type of cancer, a potentially fatal infection) or its onset (e.g. a heart attack, a stroke, a severe injury), mood symptoms can occur as a part of a psychological response to being diagnosed and/or having to cope with a severe medical condition. In the absence of evidence of a physiological link between the medical condition and the mood symptoms, the appropriate mental disorder (e.g. adjustment disorder, a mood disorder) rather than secondary mood syndrome should be diagnosed.

Boundary with delirium due to disease classified elsewhere

Mood symptoms can occur in the context of delirium due to disease classified elsewhere. Delirium is characterized by disturbed attention (i.e. reduced ability to direct, focus, sustain and shift attention) and awareness (i.e. reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day, accompanied by other cognitive impairment such as memory deficit, disorientation or impairment in language, visuospatial ability or perception. In contrast, mood symptoms in secondary mood syndrome occur in the absence of disturbed attention or severe cognitive impairment. If mood symptoms are judged to be better explained by delirium due to disease classified elsewhere, an additional diagnosis of secondary mood syndrome is not warranted.

Boundary with dementia

Mood symptoms can occur in the context of dementia, which is characterized by a decline from a previous level of cognitive functioning with impairment in two or more cognitive domains (e.g. memory, executive functions, attention, language, social cognition and judgement, psychomotor speed, visuoperceptual or visuospatial abilities). In contrast, secondary mood syndrome is not accompanied by marked cognitive impairment. The presence of mood symptoms in the context of dementia can be recorded using the *mood symptoms in dementia* specifier. If the mood symptoms are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary mood syndrome is not warranted.

Boundary with secondary catatonia syndrome

Certain symptoms of secondary catatonia syndrome are similar to those observed during manic, depressive or mixed episodes (e.g. stupor or mutism in secondary catatonia is similar to psychomotor retardation in a depressive episode; agitation or impulsivity in secondary catatonia syndrome is similar to increased activity and impulsive reckless behaviour in a manic episode). In secondary catatonia syndrome, these symptoms occur in conjunction with other catatonic symptoms (e.g. abnormal psychomotor activity such as mannerisms, waxy flexibility or posturing), which are not characteristic of secondary mood syndrome.

Boundary with mood symptoms caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary mood syndrome, it is important to rule out the possibility that a medication or substance is causing the mood symptoms instead of –or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause depressive or manic symptoms (e.g. steroids or alpha-interferon) at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the mood symptoms should be established (i.e. the mood symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and mood symptoms who are also using a psychoactive substance known to cause mood symptoms, in the context of either intoxication or withdrawal (e.g. euphoric mood due to stimulant intoxication, dysphoric mood due to cocaine withdrawal). In such cases, if the intensity or duration of the mood symptoms is substantially in excess of mood disturbances that are characteristic of the substance-specific intoxication or withdrawal syndrome, then substance-induced mood disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing depressive mood syndromes include:

- diseases of the nervous system (e.g. cerebrovascular disease, Huntington disease, normal-pressure hydrocephalus, multiple sclerosis, Parkinson disease, stroke);
- certain infectious or parasitic diseases (candidosis, HIV disease, Lyme borreliosis, toxoplasmosis);
- diseases of the immune system (e.g. systemic lupus erythematosus);
- endocrine, nutritional or metabolic diseases (e.g. Cushing syndrome, hypercalcaemia, hyperglycaemia, hypermagnesaemia, hypoadrenalism, hypothyroidism, iron deficiency);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage);
- neoplasms (e.g. malignant neoplasm of pancreas leading to a paraneoplastic disorder of the nervous system, brain or spinal cord).

Brain disorders and general medical conditions that have been shown to be capable of producing manic mood syndromes include:

- diseases of the nervous system (e.g. movement disorders such as Huntington disease, multiple sclerosis, seizures, stroke);

- certain infectious or parasitic diseases (e.g. neurosyphilis);
- diseases of the immune system (e.g. systemic lupus erythematosus);
- endocrine, nutritional or metabolic diseases (e.g. hyperadrenalism, hypocalcaemia, hypomagnesaemia, thyrotoxicosis, Wilson disease);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury, concussion, traumatic haemorrhage, injury of optic or acoustic nerve);
- neoplasms (e.g. neoplasms of brain or meninges).

6E63 Secondary anxiety syndrome

Essential (required) features

- The presence of prominent anxiety symptoms (e.g. excessive worry, intense fear that is out of proportion to actual danger, panic attacks) is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings (as opposed to being a psychological reaction to having the medical condition). This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the anxiety symptoms (e.g. onset, remission, response of the anxiety symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. anxiety and fear-related disorders, mood disorders, disorders specifically associated with stress, obsessive-compulsive and related disorders) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with anxiety and fear-related disorders

Determining whether anxiety symptoms are due to a medical condition as opposed to manifestations of a mental disorder is often difficult because the clinical presentations may be similar. In some cases, the anxiety symptoms may reach the point of warranting a separate diagnosis of an anxiety or fear-related disorder, or a pre-existing anxiety or fear-related disorder may be exacerbated. Diagnosing secondary anxiety syndrome depends on establishing the presence of a medical condition that can cause anxiety symptoms and a temporal relationship between the medical condition and the anxiety symptoms. If the clinical features are atypical for anxiety and fear-related disorders (e.g. a new onset of unexpected panic attacks in an older adult), secondary anxiety syndrome is more likely.

Boundary with anxiety symptoms that are precipitated by the stress of being diagnosed with or worrying about a medical condition

Depending on the nature of the medical condition (e.g. a life-threatening type of cancer, a potentially fatal infection) or its onset (e.g. a heart attack, a stroke, a severe injury), anxiety symptoms can occur as a part of a psychological response to being diagnosed and/or having to cope with a severe medical condition. In the absence of evidence of a physiological link between the medical condition and the anxiety symptoms, a diagnosis of secondary anxiety syndrome is not warranted. Instead, the appropriate mental disorder can be diagnosed (e.g. an anxiety or fear-related disorder, adjustment disorder, hypochondriasis).

Boundary with delirium due to disease classified elsewhere

Anxiety symptoms can occur in the context of delirium due to disease classified elsewhere. Delirium is characterized by disturbed attention (i.e. reduced ability to direct, focus, sustain and shift attention) and awareness (i.e. reduced orientation to the environment) that develops over a short period of time and tends to fluctuate during the course of a day, accompanied by other cognitive impairment such as memory deficit, disorientation or impairment in language, visuospatial ability or perception. In contrast, panic attacks or other anxiety symptoms in secondary anxiety syndrome occur in the absence of disturbed attention or severe cognitive impairment. If the anxiety symptoms are judged to be better explained by delirium due to disease classified elsewhere, an additional diagnosis of secondary anxiety syndrome is not warranted.

Boundary with dementia

Anxiety symptoms can occur in the context of dementia, which is characterized by a decline from a previous level of cognitive functioning with impairment in two or more cognitive domains (e.g. memory, executive functions, attention, language, social cognition and judgement, psychomotor speed, visuoperceptual or visuospatial abilities). In contrast, secondary anxiety syndrome is not accompanied by marked cognitive impairment. The presence of anxiety symptoms in the context of dementia can be recorded using the *anxiety symptoms in dementia* specifier. If the anxiety symptoms are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary anxiety syndrome is not warranted.

Boundary with anxiety symptoms caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary anxiety syndrome, it is important to rule out the possibility that a medication or substance is causing the anxiety symptoms instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause anxiety symptoms at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the anxiety symptoms should be established (i.e. the anxiety symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and anxiety symptoms who are also using a psychoactive substance known to cause anxiety, in the context of either intoxication or withdrawal (e.g. panic attacks during anxiolytic or opioid withdrawal, physiological symptoms of excessive autonomic arousal in stimulant intoxication). In such cases, if the intensity or duration of the anxiety symptoms is substantially in excess of anxiety symptoms that are characteristic of the substance-specific intoxication or withdrawal syndrome, then substance-induced anxiety disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing anxiety syndromes include:

- diseases of the nervous system (e.g. encephalitis, seizures);
- diseases of the circulatory system (e.g. cardiac arrhythmia, congestive heart failure, hyperkinetic heart syndrome, mitral valve prolapse, pulmonary thromboembolis);
- diseases of the ear or mastoid process (e.g. acute vestibular syndrome);
- diseases of the respiratory system (e.g. asthma, chronic obstructive pulmonary disease);
- endocrine, nutritional or metabolic diseases (e.g. hyperadrenalism, hypercalcaemia, hypermagnesaemia, hyperthyroidism, hypoglycaemia, hypoparathyroidism);
- neoplasms (e.g. malignant phaeochromocytoma of adrenal gland, neoplasms of brain or meninges).

6E64 Secondary obsessive-compulsive or related syndrome

Essential (required) features

- The presence of prominent symptoms that are characteristic of obsessive-compulsive and related disorders, such as obsessions, compulsions, skin picking, hair pulling or other body-focused repetitive behaviours, is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the symptoms (e.g. onset, remission, response to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by another mental disorder (e.g. an obsessive-compulsive or related disorder) or the effects of a medication or substance, including withdrawal effects.
- The symptoms do not meet the diagnostic requirements for secondary tics, classified in the grouping of movement disorders in Chapter 8 on diseases of the nervous system.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with obsessive-compulsive and related disorders

Determining whether obsessive-compulsive or related symptoms are due to a medical condition as opposed to manifestations of a primary mental disorder is often difficult because the clinical presentations may be similar. Establishing the presence of a potentially explanatory medical condition that can cause obsessive-compulsive or related symptoms and the temporal relationship between the medical condition and the primary obsessive-compulsive or related symptoms is critical in diagnosing secondary obsessive-compulsive or related syndrome. Secondary obsessive-compulsive or related syndrome is often characterized by clinical features that would be atypical for obsessive-compulsive and related disorders, such as late age of onset, sudden appearance of symptoms, or accompanying cognitive impairment or focal neurological signs.

Boundary with obsessive-compulsive and related symptoms caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary obsessive-compulsive or related syndrome, it is important to rule out the possibility that a medication or substance is causing the obsessive-compulsive or related symptoms instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause obsessive-compulsive or related symptoms at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the obsessive-compulsive or related symptoms should be established (i.e. the obsessive-compulsive or related symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and obsessive-compulsive or related symptoms who are also using a psychoactive substance known to cause obsessive-compulsive or related symptoms in the context of either intoxication or withdrawal (e.g. cocaine-induced hair pulling, obsessions or compulsions due to amfetamine intoxication). In such cases, a diagnosis of a substance-induced obsessive-compulsive or related disorder should be assigned, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing obsessive-compulsive or related syndromes include:

- diseases of the nervous system (e.g. epilepsy, Huntington disease, myoclonic disorders, Parkinson disease, paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS), secondary chorea – including chorea due to neuroacanthocytosis and McLeod syndrome, stroke);
- certain infectious or parasitic diseases (e.g. rheumatic chorea (Sydenham chorea));
- endocrine, nutritional or metabolic diseases (e.g. iron overload diseases such as pantothenate-kinase-associated neurodegeneration);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury);
- neoplasms (e.g. neoplasms of brain or meninges).

6E65 Secondary dissociative syndrome

Essential (required) features

- The presence of prominent dissociative symptoms (e.g. depersonalization, derealization, dissociative amnesia, a marked alteration in the individual's normal sense of personal identity) is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the observed symptoms.
  - The course of dissociative symptoms (e.g. onset, remission, response of the dissociative symptoms to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. dissociative disorders, disorders specifically associated with stress, schizophrenia and other primary psychotic disorders) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with dissociative disorders

Determining whether dissociative symptoms are due to a medical condition as opposed to manifestations of a primary mental disorder is often difficult because the clinical presentations may be similar. Establishing the presence of a potentially explanatory medical condition that can cause dissociative symptoms and the temporal relationship between the medical condition and the dissociative symptoms is critical in diagnosing secondary dissociative syndrome.

Boundary with dissociative symptoms caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary dissociative syndrome, it is important to rule out the possibility that a medication or substance is causing the dissociative symptoms instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause dissociative symptoms at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the dissociative symptoms should be established (i.e. the dissociative symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and dissociative symptoms who are also using a psychoactive substance known to cause dissociative symptoms, in the context of either intoxication or withdrawal (e.g. amnesia due to ketamine or phencyclidine intoxication, depersonalization due to dextromethorphan intoxication).

Boundary with dissociative symptoms that are precipitated by the stress of being diagnosed with a medical condition

The stress of a medical diagnosis can precipitate dissociative symptoms (e.g. depersonalization, derealization). Depending on the nature of the medical condition (e.g. a life-threatening type of cancer, a potentially fatal infection) or its onset (e.g. a heart attack, a stroke, a severe injury), being diagnosed and/or having to cope with a severe medical condition can be experienced as a traumatic event, which may trigger dissociative symptoms. In the absence of evidence of a physiological link between the medical condition and the dissociative symptoms, a diagnosis of secondary dissociative syndrome is not warranted. Instead, the appropriate mental disorder can be diagnosed (e.g. adjustment disorder, depersonalization-derealization disorder).

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing dissociative syndromes include:

- diseases of the nervous system (e.g. encephalitis, migraine, seizures, stroke);
- endocrine, nutritional or metabolic diseases (e.g. hyperglycaemia);
- injury, poisoning or certain other consequences of external causes (e.g. intracranial injury);
- neoplasms (e.g. neoplasms of brain).

6E66 Secondary impulse control syndrome

Essential (required) features

- The presence of prominent symptoms that are characteristic of impulse control disorders or disorders due to addictive behaviours (e.g. stealing, fire setting, aggressive outbursts, compulsive sexual behaviour, excessive gambling) is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the symptoms (e.g. onset, remission, response to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. an impulse control disorder or a disorder due to addictive behaviours), or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with primary impulse control disorder or disorders due to addictive behaviours

Determining whether disturbances of impulse control are due to medical conditions classified elsewhere or are manifestations of an impulse control disorder or a disorder due to addictive behaviours is often difficult because the clinical presentations may be similar. Establishing the presence of a potentially explanatory medical condition that can cause disturbances of impulse control and the temporal relationship between the medical condition and the disturbances of impulse control is critical in diagnosing secondary impulse control syndrome. Compared to impulse control disorders or disorders due to addictive behaviours, secondary impulse control syndrome is more likely to be associated with atypical clinical features, such as a later age of onset or the presence of disturbances of impulse control in individuals who generally exhibit low levels of disinhibition or negative emotionality.

Boundary with delirium and dementia

Disturbances of impulse control or addictive behaviour can occur in the context of delirium or dementia. Secondary impulse control syndrome is characterized by disturbances of impulse control or addictive behaviours (e.g. aggressive outbursts, compulsive sexual behaviour) occurring in the absence of severe cognitive impairment. In contrast, delirium is characterized by fluctuating levels of consciousness and autonomic disturbances, while dementia is characterized by severe memory impairment as well as impairments in other domains of cognitive functioning. Disturbances of impulse control or addictive behaviour in the context of dementia may be recorded using one of the behavioural or psychological disturbances in dementia specifiers (e.g. *agitation or aggression in dementia*, *disinhibition in dementia*), if applicable. If the symptoms are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary impulse control syndrome is not warranted.

Boundary with secondary personality change

Disturbances of impulse control or addictive behaviour can occur as part of secondary personality change. If the disturbances of impulse control are accompanied by other features of personality disturbance that are also judged to be due to a medical condition classified elsewhere, a diagnosis of secondary personality change should be assigned instead.

Boundary with disturbances of impulse control or addictive behaviour caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary impulse control syndrome, it is important to rule out the possibility that a medication or substance is causing the symptoms instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause disturbances of impulse control or addictive behaviour at the dose and duration at which it has been administered (e.g. dopamine agonists such as pramipexole for Parkinson disease or restless legs syndrome). Second, a temporal relationship between the medication use and the onset of the symptoms should be established (i.e. the symptoms began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition and disturbances of impulse control who are also using a psychoactive substance known to cause disturbances of impulse control or addictive behaviour, in the

context of either intoxication or withdrawal (e.g. compulsive sexual behaviour due to cocaine intoxication, aggressive outburst due to methamfetamine intoxication). In such cases, substance-induced impulse control disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing impulse control syndromes include:

- diseases of the nervous system (e.g. encephalitis, seizures, stroke, Klüver–Bucy syndrome);
- developmental anomalies (e.g. male with double or multiple Y [xyy syndrome]);
- endocrine diseases;
- injury, poisoning or certain other consequences of external causes (e.g. intracranial injury);
- neoplasms (e.g. neoplasms of brain).

6E67 Secondary neurocognitive syndrome

Essential (required) features

- The presence of deficits in neurocognitive functioning that do not meet the diagnostic requirements for delirium, mild neurocognitive disorder, amnestic disorder or dementia, and do not have their onset during the developmental period, is required for diagnosis.
- The neurocognitive symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings (as opposed to being a psychological reaction to having the medical condition). This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the deficits in neurocognitive functioning (e.g. onset, remission, response to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not judged to be better explained by disturbance of consciousness or altered mental status (e.g. due to seizure, traumatic brain injury, stroke or the effects of medication), a neurodevelopmental disorder, another mental disorder (e.g. schizophrenia or another primary psychotic disorder, a mood disorder, post-traumatic stress disorder, a dissociative disorder) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are of short duration (e.g. less than 1 month), and it is expected that the neurocognitive symptoms will remit with treatment of the etiological medical condition.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with neurocognitive disorders

Delirium, mild neurocognitive disorder, amnestic disorder and dementia can all be caused by medical conditions classified elsewhere. If the presentation meets the diagnostic requirements for any of these neurocognitive disorders, that diagnosis should be assigned rather than secondary neurocognitive syndrome. If the presence of a specific etiological medical condition has not been established, a diagnosis of other specified neurocognitive disorder should be assigned.

Boundary with disorders of intellectual development

Presentations that meet the diagnostic requirements for disorder of intellectual development and are judged to be the direct pathophysiological consequence of a medical condition are not diagnosed as secondary neurocognitive syndrome because, by convention, disorders of intellectual development are diagnosed regardless of etiology. In these cases, disorder of intellectual development and the underlying medical condition should be diagnosed, and a diagnosis of secondary neurocognitive syndrome is not assigned.

Boundary with secondary neurodevelopmental syndrome

Secondary neurodevelopmental syndrome may also be characterized by cognitive impairment that is judged to be due to a medical condition. If the cognitive impairment has its onset during the developmental period, the appropriate diagnosis is secondary neurodevelopmental syndrome rather than secondary neurocognitive syndrome.

Boundary with other mental disorders that may be associated with cognitive impairment

Deficits in cognitive functioning may be a presenting or associated feature of a variety of mental disorders (e.g. developmental speech or language disorders, developmental learning disorders, schizophrenia or other primary psychotic disorders, mood disorders). Secondary neurocognitive syndrome should be diagnosed only if a medical condition has been identified that is judged to be the direct physiological cause of the neurocognitive impairment.

Boundary with deficits in cognitive functioning caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary neurocognitive syndrome, it is important to rule out the possibility that a medication or substance is causing the deficits in neurocognitive functioning instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause deficits in cognitive functioning at the dose and duration at which it has been administered. Second, a temporal relationship between the medication use and the onset of the deficits in neurocognitive functioning should be established (i.e. deficits in neurocognitive functioning began after administration of the medication and/or remitted once the medication was discontinued). The same reasoning applies to individuals with a medical condition who are using a psychoactive substance known to cause deficits in neurocognitive functioning (e.g. memory loss due to sedative intoxication, disturbed attention/concentration and orientation due to alcohol intoxication). In such cases, delirium, amnestic disorder or dementia due to psychoactive substances (including medications) or mild neurocognitive disorder is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Potentially explanatory medical conditions

Brain disorders and general medical conditions that have been shown to be capable of producing neurocognitive syndromes include:

- diseases of the nervous system (e.g. adrenoleukodystrophy, cerebral arteritis, seizures);
- certain infectious or parasitic diseases (e.g. cryptococcosis, Lyme borreliosis, neurosyphilis);
- diseases of the blood or blood-forming organs (e.g. sickle cell disorders);
- diseases of the digestive system (e.g. hepatic failure, intestinal malabsorption);
- diseases of the genitourinary system (e.g. renal failure);
- diseases of the immune system (e.g. eosinophilia, systemic lupus erythematosus);
- endocrine, nutritional or metabolic diseases (e.g. hypercalcaemia, hypo- or hyperglycaemia, hypothyroidism);
- neoplasms (e.g. neoplasms of brain).

6E68 Secondary personality change

Essential (required) features

- The presence of personality disturbance (e.g. marked apathy, indifference, suspiciousness, paranoid ideation, disinhibition) that represents a change from the individual's previous characteristic personality pattern is required for diagnosis.
- The personality change is judged to be the direct pathophysiological consequence of a medical condition, based on evidence from the history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the observed symptoms.
  - The course of the personality change (e.g. onset, remission, response of the personality disturbance to treatment of the etiological medical condition is consistent with causation by the medical condition).
  - The symptoms are not better accounted for by delirium, dementia, another mental disorder (e.g. personality disorder, impulse control disorders, secondary impulse control or addictive behaviour syndrome) or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with personality disorder and personality difficulty

Establishing the presence of a potentially explanatory medical condition that can cause personality change and the temporal relationship between the medical condition and the personality change is critical in diagnosing secondary personality change. Personality is relatively stable over time, and personality disorder and personality difficulty are usually evident by early adulthood. In contrast, secondary personality change has its onset following or coincident with the onset of a medical condition that is judged to be its direct pathophysiological cause, and is characterized by the emergence of personality traits that represent a change from the individual's previous characteristic personality pattern (e.g. marked apathy, indifference, suspiciousness, paranoid ideation, disinhibition).

Boundary with dementia

Personality change can occur in the context of dementia, which is characterized by a decline from a previous level of cognitive functioning with impairment in two or more cognitive domains (e.g. memory, executive functions, attention, language, social cognition and judgement, psychomotor speed, visuoperceptual or visuospatial abilities). In secondary personality change, the emergence of personality traits that represent a change from the individual's previous characteristic personality pattern is not accompanied by marked cognitive impairment. The emergence of problematic personality features in the context of dementia may be recorded using one of the behavioural or psychological disturbances in dementia specifiers (e.g. *apathy in dementia*, *agitation or aggression in dementia*, *disinhibition in dementia*), if applicable. If the personality changes are judged to be due to the same medical condition as is causing the dementia, an additional diagnosis of secondary personality change is not warranted.

Boundary with personality change caused by substances or medications, including withdrawal effects

When establishing a diagnosis of secondary personality change, it is also important to rule out the possibility that a substance or medication is causing the personality disturbance instead of – or in addition to – an underlying medical condition. This involves first considering whether any of the medications being used to treat the medical condition are known to cause personality disturbance at the dose and duration at which it has been administered (e.g. apathy due to chronic cannabis use, paranoid ideation due to chronic stimulant use). Second, a temporal relationship between the medication use and the onset of the personality disturbance should be established (i.e. the personality change began after administration of the medication and/or remitted once the medication was discontinued). If the intensity or duration of the personality change is substantially in excess of symptoms that are characteristic of the substance-specific intoxication or withdrawal syndrome, then other disorder due to use of substances is the appropriate diagnosis, applying the appropriate category corresponding to the substance involved.

Boundary with secondary impulse control or addictive behaviour syndrome

Personality changes may include symptoms of disordered impulse control or addictive behaviours. If the personality changes judged to be the direct pathophysiological consequence of a medical condition are restricted to increased impulsivity or addictive behaviours, then secondary impulse control or addictive behaviour syndrome is the appropriate diagnosis rather secondary personality change.

Potentially explanatory medical conditions (examples)

Brain disorders and general medical conditions that have been shown to be capable of producing personality change include:

- diseases of the nervous system (e.g. encephalitis, Huntington disease, multiple sclerosis, seizures, stroke);
- certain infectious or parasitic diseases (e.g. HIV disease);
- endocrine, nutritional or metabolic diseases (e.g. hypo- and hyperadrenalism, hypo- and hyperthyroidism);
- injury, poisoning or certain other consequences of external causes (e.g. brain injury).

6E69 Secondary catatonia syndrome

See the section on catatonia (p. 201) for the complete CDDR for secondary catatonia syndrome.

6E6Y Other specified secondary mental or behavioural syndrome

- The presence of prominent symptoms that are characteristic of those seen in mental disorders but are not adequately captured by any of the other available categories in the grouping of secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere, is required for diagnosis.
- The symptoms are judged to be the direct pathophysiological consequence of a medical condition, based on evidence from history, physical examination or laboratory findings. This judgement depends on establishing the following.
  - The medical condition is known to be capable of producing the symptoms.
  - The course of the symptoms (e.g. onset, remission, response to treatment of the etiological medical condition) is consistent with causation by the medical condition.
  - The symptoms are not better accounted for by another mental disorder or the effects of a medication or substance, including withdrawal effects.
- The symptoms are sufficiently severe to be a specific focus of clinical attention.

6E6Z Secondary mental or behavioural syndrome, unspecified

Mental or behavioural symptoms, signs or clinical findings

This section comprises mental or behavioural symptoms that may be an important aspect of an individual's clinical presentation, or may be a reason for a clinical encounter or for treatment. It replicates one section of Chapter 21 on symptoms, signs or clinical findings, not elsewhere classified.

These categories may be used when a more precise diagnosis has not been established for various reasons (e.g. they describe transient symptoms at the time of initial encounter whose causes could not be determined; the individual was referred for investigation or treatment before a diagnosis was made; the patient failed to return for further investigation or follow-up; a more specific diagnosis could not be determined even after investigation). In these cases, the categories from this section can be used to describe the clinical presentation in the absence of a diagnosis for the underlying disorder or condition.

These categories may also be used to describe clinically important aspects of the individual's presentation when a mental disorder diagnosis has been assigned. They may be especially useful when the symptom being described has implications for treatment but is not an essential feature of the disorder itself, and does not meet the requirements for another diagnosable disorder (e.g. duration, severity, situational specificity). For example, an individual with autism spectrum disorder may be experiencing significant anxiety related to a transition to an unfamiliar environment that does not by itself meet the diagnostic requirements for any anxiety or fear-related disorder. In this case, the symptom category MB24.3 Anxiety could be assigned together with the diagnosis 6A02 Autism spectrum disorder. (The resulting diagnostic code would be 6A02/MB24.3.) Thus, additional symptom codes may be used together with the underlying diagnosis if they convey clinically important additional information.

Symptom categories should not be applied in circumstances where they do not convey any additional meaningful information. For example, applying the symptom code MB24.3 Anxiety together with a diagnosis of 6B00 Generalized anxiety disorder would be redundant because anxiety is an essential feature of the disorder itself.

Mental or behavioural symptoms, signs or clinical findings include the following groupings:

MB20 Symptoms, signs or clinical findings involving consciousness

MB21 Symptoms, signs or clinical findings involving cognition

MB22	Symptoms or signs involving motivation or energy
MB23	Symptoms or signs involving appearance or behaviour
MB24	Symptoms or signs involving mood or affect
MB25	Symptoms or signs involving form of thought
MB26	Symptoms or signs involving content of thought
MB27	Symptoms or signs involving perceptual disturbance
MB28	Symptoms or signs related to personality features
MB29	Symptoms or signs involving eating and related behaviour
MB2A	Symptoms or signs involving elimination.
MB2Y	Other specified mental or behavioural symptoms, signs or clinical findings

Also included in this section are certain categories from other parts of the chapter on symptoms, signs or clinical findings, not elsewhere classified. These categories are secondary parented under the corresponding mental or behavioural symptom grouping listed above.

MB20 Symptoms, signs or clinical findings involving consciousness

This grouping includes symptoms, signs or clinical findings indicative of a disturbance in the state or quality of awareness of oneself and the environment, alertness or clarity of the wakeful state.

MB20.0 Stupor

- Stupor refers to total or nearly total lack of spontaneous movement and marked decrease in reactivity to environment.

MB20.1 Coma

- Coma refers to an acute state lasting more than 1 hour and usually less than 1 month, in which the individual is unresponsive, lying with their eyes closed, and cannot be aroused even by vigorous and noxious stimuli. Motor responses to noxious stimulation are limited to reflexive behaviour. Etiologies include – but are not limited to – traumatic, anoxic, infectious, neoplastic, vascular, inflammatory and metabolic brain injuries.

MB20.2 Clouding of consciousness

- Clouding of consciousness refers to an impairment in the clarity of consciousness, manifested in impaired ability to comprehend aspects of the environment or the self in

relation to the environment, inattention, and abnormalities in thought processes and comprehension. It is typically accompanied by subjective experience of mental clouding described as feeling "foggy". Clouding of consciousness is a common form of cognitive disturbance in delirium, but it is not synonymous with delirium because delirium includes additional diagnostic requirements.

MB20.Y Other specified symptoms, signs or clinical findings involving consciousness

MB21 Symptoms, signs or clinical findings involving cognition

This grouping includes symptoms, signs or clinical findings indicative of a disturbance in mental abilities and processes related to attention, memory, judgement, reasoning, problem solving, decision-making or comprehension, or the integration of these functions.

MB21.0 Age-associated cognitive decline

- Age-associated cognitive decline refers to a normative (non-pathological) deterioration of higher cortical functions such as thinking, reasoning, comprehension, calculation, learning, language and judgement.

MB21.1 Amnesia

- Amnesia refers to an inability to recall past experiences, especially where recall is to be expected. It includes the following subcategories.

MB21.10 Anterograde amnesia

- Anterograde amnesia refers to an inability to recall past experiences, especially where recall is to be expected, occurring after an event (psychological or physical) presumed to be responsible for the amnesia.

MB21.11 Retrograde amnesia

- Retrograde amnesia refers to an inability to recall past experiences, especially where recall is to be expected, preceding an event (psychological or physical) presumed to be responsible for the amnesia.

MB21.12 Transient global amnesia

- Transient global amnesia refers to a time-limited episode (lasting up to 2 days) of short-term memory loss without other signs or symptoms of neurological impairment.

MB21.1Y Other specified amnesia

MB21.1Z Amnesia, unspecified

MB21.2 Anosognosia

- Anosognosia refers to a lack of awareness or failure to recognize one's own illness, symptoms or functional deficits, considered to be an aspect of the illness.

MB21.3 Confabulation

- Confabulation refers to the filling of memory gaps with fabricated, distorted or misinterpreted memories about oneself or the world, without the conscious intention to deceive.

MB21.4 Disorientation

- Disorientation refers to an impairment in or loss of awareness of the position of the self in relation to place, time, situation or other people. In severe cases, the sense of personal identity may also be lost.

MB21.5 Distractibility

- Distractibility refers to difficulty focusing on tasks, with attention being easily diverted by extraneous stimuli.

MB21.6 Impaired abstract thinking

- Impaired abstract thinking refers to an inability to use concepts and to make and understand generalizations, such as the identifying the properties or pattern shared by a variety of specific items or events.

MB21.7 Impaired executive functioning

- Impaired executive functioning refers to impairment in higher-level cognitive abilities, such as planning, sequencing, concept formation, abstracting and decision-making.

MB21.8 Impaired judgement

- Impaired judgement refers to a deficit in the capacity to make sound, reasoned and responsible decisions.

MB21.9 Perseveration

- Perseveration refers to the persistent repetition of previously used words, phrases or details that are not responsive to the demands of the situation.

MB21.A Poor concentration

- Poor concentration refers to difficulty focusing attention and sustaining the mental energy necessary to accomplish a task or goal.

MB21.B Racing thoughts

- Racing thoughts refers to a subjective perception of accelerated thought processes.

MB4B.0 Dyslexia and alexia

- Dyslexia and alexia refer to the loss – usually in adulthood – of a previous ability to read fluently and to accurately comprehend written material, that is inconsistent with general level of intellectual functioning and is acquired after the developmental period in individuals who had previously attained these skills, such as due to a stroke or other brain injury.

MB4B.1 Agnosia

- Agnosia refers to the inability to recognize objects, shapes, people, sounds or smells, which occurs despite otherwise normal functioning of the specific sense, and is not accounted for by memory impairment.

MB4B.2 Acalculia

- Acalculia refers to the loss – usually in adulthood – of a previous ability to perform simple mathematical calculations, that is inconsistent with general level of intellectual functioning and is acquired after the developmental period in individuals who had previously attained these skills, such as due to a stroke or other brain injury.

MB4B.3 Agraphia

- Agraphia refers to the loss – usually in adulthood – of a previous ability to write, that is inconsistent with general level of intellectual functioning and is acquired after the developmental period in individuals who had previously attained these skills, such as due to a stroke or other brain injury.

MB4B.4 Anomia

- Anomia refers to acquired difficulty in retrieving previously used vocabulary – particularly nouns and verbs.

MB4B.5 Dyscalculia

- Dyscalculia refers to acquired difficulty with performing simple mathematical calculations that is inconsistent with general level of intellectual functioning, with onset after the developmental period in individuals who had previously attained these skills, such as due to a stroke or other brain injury.

MB21.Y Other specified symptoms or signs involving cognition

MB21.Z Symptoms or signs involving cognition, unspecified

MB22 Symptoms or signs involving motivation or energy

This grouping includes symptoms or signs involving motivation (the process that initiates, guides and maintains goal-oriented behaviours) or energy (the strength and vitality required for sustained physical or mental activity).

MB22.0 Avolition

- Avolition refers to a general lack of drive, or lack of motivation to pursue meaningful goals (e.g. as evidenced by limited participation in work, school or socializing with others).

MB22.1 Decreased libido

- Decreased libido refers to decreased sexual desire or sexual activity compared to the patient's usual levels of sexual interest and functioning.

MB22.2 Demoralization

- Demoralization refers to loss of confidence in one's ability to cope, with associated feelings of helplessness, hopelessness and discouragement.

MB22.3 Hopelessness

- Hopelessness refers to little or no belief in a positive future.

MB22.4 Increased energy

- Increased energy refers to increased physical or mental resources for activity, typically characterized by increased capacity for work and greater efficiency in responding to stimuli.

MB22.5 Increased goal-directed activity

- Increased goal-directed activity refers to increased planning of and participation in multiple activities (e.g. sexual, occupational, political, religious) compared to the individual's typical level of activity.

MB22.6 Increased libido

- Increased libido refers to increased sexual desire or sexual activity compared to the patient's usual levels of sexual interest and functioning.

MB22.7 Tiredness

- Tiredness refers to a feeling of reduced alertness and an accompanying decrease in mental acuity, in some cases resulting in an impulse or tendency to fall asleep.

MG22 Fatigue

- A feeling of exhaustion, lethargy, or decreased energy, usually experienced as a weakening or depletion of one's physical or mental resource and characterized by a decreased capacity for work and reduced efficiency in responding to stimuli. Fatigue is normal following a period of exertion, mental or physical, but sometimes may occur in the absence of such exertion as a symptom of health conditions.

MB22.Y Other specified symptoms or signs involving motivation or energy

MB22.Z Symptoms or signs involving motivation or energy, unspecified

MB23 Symptoms or signs involving appearance or behaviour

This grouping includes symptoms or signs involving the individual's appearance or behaviour relevant to the clinical encounter.

MB23.0 Aggressive behaviour

- Aggressive behaviour refers to actions intended to threaten or hurt another person or to damage property that may be physical, verbal or symbolic (e.g. acting against the other person's interests). Aggressive behaviour may be appropriate and self-protective, or inappropriate, hostile and destructive.

MB23.1 Antisocial behaviour

- Antisocial behaviour refers to behaviour in which the basic rights of others or major age-appropriate societal norms, rules or laws are violated.

MB23.2 Avoidance behaviour

- Avoidance behaviour refers to the act of keeping away from circumstances, situations or stimuli that cause anxiety or other negative emotions in the individual.

MB23.3 Bradyphrenia

- Bradyphrenia refers to slowness of thoughts or fatigability of initiative.

MB23.4 Compulsions

- Compulsions refer to repetitive behaviours or rituals (e.g. washing, checking) or mental acts (e.g. repeating words silently) that the individual feels driven to perform in response to an obsession, according to rigid rules, or to achieve a sense of "completeness".

MB23.5 Coprolalia

- Coprolalia refers to involuntary swearing or the involuntary utterance of obscene words or socially inappropriate and derogatory remarks, often in Tourette syndrome.

MB23.6 Disorganized behaviour

- Disorganized behaviour refers to behaviour including posture, gait and other activity that is unpredictable or not goal-directed (e.g. shouting at strangers on the street).

MB23.7 Dishevelled appearance

- Dishevelled appearance refers to untidy or unkempt appearance, reflecting a lack of attention to one or more aspects of hygiene, grooming or dress.

MB23.8 Disruptive behaviour

- Disruptive behaviour refers to behaviour that causes disorder and turmoil in others or one's environment (e.g. angry outbursts, arguments, disobedience).

MB23.9 Echolalia

- Echolalia refers to the automatic repetition of vocalizations, words or phrases uttered by another person, which may be immediate or delayed (e.g. repetition of phrases earlier heard on television), without meaningful communicative function. Echolalia is a common feature of communication abnormalities in autism spectrum disorder, but may also occur in other mental, behavioural and neurodevelopmental disorders and certain neurological conditions; among children with severe visual impairment; and occasionally in typically developing children. Echolalia does not include repetition as a normal feature of language acquisition in early childhood development.

MB23.A Excessive crying of child, adolescent or adult

- Excessive crying of child, adolescent or adult refers to episodes of crying for several hours per day for more than several days a week for several weeks in an otherwise healthy child, adolescent or adult.

MB23.C Increased sociability

- Increased sociability refers to a decrease or loss of normal social inhibitions manifested in increased impulses to be with and talk to other people, including overfamiliarity, compared to the individual's typical level of activity.

MB23.D Mutism

- Mutism refers to a lack of verbal output that may be generalized or restricted to specific situations.

MB23.E Non-suicidal self-injury

- Non-suicidal self-injury refers to intentional self-inflicted injury to the body – most commonly cutting, scraping, burning, biting or hitting – with the expectation that the injury will lead to only minor physical harm.

MB23.F Odd or peculiar appearance

- Odd or peculiar appearance refers to grooming, clothing or other aspects of personal appearance that are eccentric, unusual or peculiar, and inconsistent with cultural or subcultural norms.

MB23.G Odd or peculiar behaviour

- Odd or peculiar behaviour refers to behaviour including posture and gait that is eccentric, unusual or peculiar, and is inconsistent with cultural or subcultural norms.

MB23.H Panic attack

- Panic attack refers to a discrete episode of intense fear or apprehension accompanied by the rapid and concurrent onset of a number of characteristic symptoms. These symptoms may include – but are not limited to – palpitations or increased heart rate, sweating, trembling, sensations of shortness of breath, feelings of choking, chest pain, nausea or abdominal distress, feelings of dizziness or lightheadedness, chills or hot flushes, tingling or lack of sensation in extremities (i.e. paraesthesias), depersonalization or derealization, fear of losing control or going mad, and fear of imminent death. Panic attacks can appear "out of the blue" or can be triggered by particular situations.

MB23.J Poor personal hygiene

- Poor personal hygiene refers to unwillingness or inability to maintain a level of personal cleanliness that is in keeping with the standards of the person's culture, society or setting, such as not washing or brushing one's teeth.

MB23.K Poverty of speech

- Poverty of speech refers to a general lack of the unprompted content and elaboration normally seen in speech that is attributed to poverty of thought. It is one of the negative symptoms of schizophrenia.

MB23.L Pressured speech

- Pressured speech refers to speech in which the person feels undue pressure to get the words out. The person's speech is usually rapid, loud and emphatic, and may be difficult or impossible to interrupt. Frequently, the person talks without any social stimulation, and may continue to talk even though no one is listening.

MB23.M Psychomotor agitation

- Psychomotor agitation refers to excessive motor activity, usually manifested in purposeless behaviours such as fidgeting, shifting, fiddling, inability to sit or stand still, or wringing of the hands.

MB23.N Psychomotor retardation

- Psychomotor retardation refers to a visible generalized slowing of movements and speech.

MB23.Q Social withdrawal

- Social withdrawal refers to a retreat from relationships and other social interactions.

MB23.R Suicide attempt

- Suicide attempt refers to a specific episode of self-harming behaviour undertaken with the conscious intention of ending one's life.

MB23.S Suicidal behaviour

- Suicidal behaviour refers to concrete actions, such buying a gun or stockpiling medication, that are taken in preparation for fulfilling a wish to end one's life but that do not constitute an actual suicide attempt.

MA81 Speech dysfluency

- Speech dysfluency is characterized by the frequent or pervasive disruption of the rhythmic flow of speech that arises subsequent to the developmental period (i.e. adult onset) and is outside the limits of normal variation and results in reduced intelligibility and significantly affects communication. It can involve repetitions of sounds, syllables or words, prolongations, word breaks, blockage of production, excessive use of interjections, and rapid short bursts of speech.

MB23.Y Other specified symptoms or signs involving appearance and behaviour

MB23.Z Symptoms or signs involving appearance and behaviour, unspecified

MB24 Symptoms or signs involving mood or affect

This grouping includes symptoms or signs involving the regulation and expression of emotions or feeling states.

MB24.0 Ambivalence

- Ambivalence refers to conflicting ideas, wishes or feelings towards a person, thing or situation that are distressing and may create difficulties in making decisions.

MB24.1 Anger

- Anger refers to an emotional state related to one's psychological interpretation of having been threatened that may range in intensity from mild irritation to intense fury and rage.

MB24.2 Anhedonia

- Anhedonia refers to an inability to experience pleasure from normally pleasurable activities.

MB24.3 Anxiety

- Anxiety refers to apprehensiveness or anticipation of future danger or misfortune accompanied by a feeling of worry, distress or somatic symptoms of tension. The focus of anticipated danger may be internal or external.

MB24.4 Apathy

- Apathy refers to a reduction or lack of feeling, emotion, interest or concern – a state of indifference.

MB24.5 Depressed mood

- Depressed mood refers to a negative affective state characterized by low mood, sadness, emptiness, hopelessness or dejection.

MB24.6 Disturbance of affect

- Disturbance of affect refers to a disturbance in the expression or outward manifestation of mood. It includes the following subcategories.

MB24.60 Constricted affect

- Constricted affect refers to a marked reduction in the expressive range and intensity of affect, but less than is observed in Blunted affect.

MB24.61 Blunted affect

- Blunted affect refers to a severe reduction in the expressive range and intensity of affect, but less than is observed in Flat affect.

MB24.62 Flat affect

- Flat affect refers to absence or near absence of any sign of affective expression.

MB24.63 Labile affect

- Labile affect refers to marked variability in emotional expression, with repeated, rapid and abrupt shifts.

MB24.64 Inappropriate affect

- Inappropriate affect refers to affective expression that is discordant with the content of the person's speech or ideation, or incompatible with the demands of a particular situation.

MB24.6Y Other specified disturbance of affect

MB24.6Z Disturbance of affect, unspecified

MB24.7 Dysphoria

- Dysphoria refers to an unpleasant mood state, which can include feelings of depression, anxiety, discontent, irritability and unhappiness.

MB24.8 Elevated mood

- Elevated mood refers to a positive mood state typically characterized by increased energy and self-esteem, which may be out of proportion to the individual's life circumstances.

MB24.9 Euphoria

- Euphoria refers to an exaggerated feeling of physical and emotional well-being and vitality.

MB24.A Fear

- Fear refers to an emotional response to perceived imminent threat or danger associated with urges to flee or fight.

MB24.B Feelings of guilt

- Feelings of guilt refer to remorse related to past events or one's past actions (or inaction), thoughts or desires.

MB24.C Irritability

- Irritability refers to a mood state characterized by being easily annoyed and provoked to anger, out of proportion to the circumstances.

MB24.D Leaden paralysis

- Leaden paralysis refers to a feeling that one's arms or legs are as heavy as lead, associated with a form of depression that also commonly includes overeating and oversleeping.

MB24.E Mental rumination

- Mental rumination refers to mental preoccupation with negative events, personal characteristics or failures.

MB24.F Restlessness

- Restlessness refers to a feeling of being unable to keep still.

MB24.G Tantrum

- Tantrum refers to an emotional outburst – usually among children or those in emotional distress – that is typically characterized by stubbornness, crying, screaming, defiance, anger, a resistance to attempts at pacification, and in some cases hitting or other violent behaviour.

MB24.H Worry

- Worry refers to unpleasant thoughts that are difficult to control, related to anticipated potential negative events.

MB24.Y Other specified symptoms or signs involving mood or affect

MB24.Z Symptoms or signs involving mood or affect, unspecified

MB25 Symptoms or signs involving form of thought

This grouping includes symptoms or signs involving the logical sequence and coherence of thought, typically manifested in speech or writing, including thought disorder (circumstantiality, tangentiality, disorganized thinking and incoherence), flight of ideas, neologisms and thought blocking.

MB25.0 Symptoms or signs of thought disorder

- Symptoms or signs of thought disorder refer to disturbances in the associative thought process, typically manifested in speech or writing, that range from circumstantiality to incoherence. These may be indicative of schizophrenia and other primary psychotic disorders, but can also occur in other mental disorders (e.g. delirium). It includes the following subcategories.

MB25.00 Circumstantiality

- Circumstantiality refers to a relatively mild disturbance in the associative thought process, typically manifested in speech or writing, exemplified by delay in getting to the point because of the interpolation of unnecessary details and irrelevant parenthetical remarks.

MB25.01 Tangentiality

- Tangentiality refers to a disturbance in the associative thought process, typically manifested in speech, in which the person tends to digress readily from the topic under discussion to other topics through associations, without ever returning to the original topic.

MB25.02	Disorganized thinking

- Disorganized thinking refers to a disturbance in the associative thought process, typically manifested in speech, in which the person shifts suddenly from one topic to another that is unrelated or minimally related to the first, and gives no indication of being aware of the disconnectedness or illogicality of their thinking.

MB25.03	Incoherence

- Incoherence refers to speech or thinking that is so disorganized that it is essentially incomprehensible to others.

MB25.0Y	Other specified symptoms or signs of thought disorder

MB25.0Z	Symptoms or signs of thought disorder, unspecified

MB25.1	Flight of ideas

- Flight of ideas refers to a nearly continuous flow of thoughts, usually manifested in speech, with rapid changes from topic to topic that are often based on understandable associations, distracting stimuli or plays on words. In severe cases, the changes may be so rapid that speech is disorganized and incoherent.

MB25.2	Neologisms

- Neologisms refer to the invention of new words that have meaning only to the person using them. It may also include the use of existing words in ways that are inconsistent with their common meaning.

MB25.3	Thought blocking

- Thought blocking refers to a phenomenon usually manifested in the person's speech being suddenly interrupted by silences, experienced as a quick and total emptying of the mind.

MB25.Y	Other specified symptoms or signs of form of thought

MB25.Z	Symptoms or signs of form of thought, unspecified

MB26 Symptoms or signs involving content of thought

This grouping includes symptoms or signs involving content of thought include delusions, experiences of influence, passivity, and control, grandiosity, homicidal ideation, identity disturbance, obsessions, overvalued ideas, paranoid ideation, referential thinking, suspiciousness and suicidal ideation.

MB26.0 Delusion

- Delusion refers to a belief that is demonstrably untrue or not shared by others, usually based on incorrect inference about external reality. The belief is firmly held with conviction and is not, or is only briefly, susceptible to modification by experience or evidence that contradicts it. The belief is not ordinarily accepted by other members or the person's culture or subculture (i.e. it is not an article of religious faith). It includes the following subcategories.

MB26.00 Bizarre delusion

- Bizarre delusion refers to a delusion that involves a phenomenon that would be regarded as physically impossible within the person's cultural context.

MB26.01 Delusion of being controlled

- Delusion of being controlled refers to a delusion that involves an external force or person controlling the individual's feelings, impulses, thoughts or behaviour.

MB26.02 Delusion of guilt

- Delusion of guilt refers to a delusion involving exaggerated or inappropriate responsibility, need for punishment or retribution, or disproportionate consequences of the individual's actions – such as that a minor error in the past will lead to disaster, that the person has committed a sin or horrible crime and should be punished severely, or that the person is responsible for a horrible outcome with which there can be no possible connection.

MB26.03 Delusion of reference

- Delusion of reference refers to a delusion that events, objects or other people in the person's immediate environment have a particular and unusual personal significance – usually of a negative or pejorative nature.

MB26.04	Erotomanic delusion

- Erotomanic delusion refers to a delusion that another person, usually of higher status, is in love with the individual.

MB26.05	Grandiose delusion

- Grandiose delusion refers to a delusion of inflated worth, power, knowledge, identity or a special relationship with a deity or famous person.

MB26.06	Jealous delusion

- Jealous delusion refers to a delusion that the individual's sexual partner is unfaithful.

MB26.07	Persecutory delusion

- Persecutory delusion refers to a delusion in which the central theme is that the individual (or someone to whom they are close) is being attacked, mocked, harassed, cheated, conspired against or persecuted.

MB26.08	Religious delusion

- Religious delusion refers to a delusion involving religious or spiritual themes or subject matter that other members of the person's religious group do not accept as possible.

MB26.09	Somatic delusion

- Somatic delusion refers to a delusion involving the functioning or appearance of the individual's body, including of having a serious disease.

MB26.0A	Nihilistic delusion

- Nihilistic delusion refers to a delusion that the self, part of the self, part of the body, other people or the whole world has ceased to exist.

MB26.0B	Misidentification delusion

- Misidentification delusion refers to a delusion that people in the individual's environment, which may include family members and loved ones, are imposters or actors, or are otherwise not who they seem to be.

MB26.0C	Delusion of impoverishment

- Delusion of impoverishment refers to a delusional conviction that the person is currently destitute or soon will be, or that they do not have the necessary financial resources to live on, in spite of evidence to the contrary.

MB26.0Y	Other specified delusion

MB26.0Z	Delusion, unspecified

MB26.1	Experiences of influence, passivity and control

- Experiences of influence, passivity and control refer to the experience that the individual's feelings, impulses, thoughts, bodily functions or behaviour are under the control of another person or other external force instead of under their own control. These experiences may or may not be accompanied by a delusional belief that provides an explanation for the subjective experience. They include the following subcategories.

MB26.10	Thought broadcasting

- Thought broadcasting refers to the experience that the person's thoughts are accessible by others so that others know what they are thinking.

MB26.11	Thought insertion

- Thought insertion refers to the experience that certain thoughts are being placed in the individual's mind by others.

MB26.12	Thought withdrawal

- Thought withdrawal refers to the experience that the person's thoughts are being removed by an outside person or force.

MB26.1Y	Other specified experiences of influence, passivity and control

MB26.1Z	Experiences of influence, passivity and control, unspecified

MB26.2 Grandiosity

- Grandiosity refers to exaggerated self-esteem or an unrealistic belief in one's superiority, importance, capacities or identity.

MB26.3 Homicidal ideation

- Homicidal ideation refers to thoughts, ideas or ruminations about killing another person, which range from vague ideas of revenge to detailed and fully formulated plans, but do not include actual homicidal attempts.

MB26.4 Identity disturbance

- Identity disturbance refers to distortion or inconsistency in the sense or view of sameness and historical continuity of the individual's self.

MB26.5 Obsessions

- Obsessions refer to repetitive and persistent thoughts (e.g. of contamination), images (e.g. of violent scenes) or impulses/urges (e.g. to stab someone) that are experienced as intrusive and unwanted, and are commonly associated with anxiety.

MB26.6 Overvalued ideas

- Overvalued ideas refer to unreasonable and sustained beliefs that are maintained with less than delusional intensity (i.e. the person is able to acknowledge the possibility that the belief may not be true). An alternative use of this term is to refer to conventional or plausible thoughts (e.g. religious concepts, political ideas, excessively idealistic beliefs) that are held with such a level of intensity that the person's life is taken up by them.

MB26.7 Paranoid ideation

- Paranoid ideation refers to ideation, not held with delusional intensity, involving suspiciousness or beliefs of being harassed, persecuted or unfairly treated by others.

MB26.8 Referential thinking

- Referential thinking refers to ideation, not held with delusional intensity, that random or coincidental events are of particular and unusual significance to the person.

MB26.9 Suspiciousness

- Suspiciousness refers to ideation in which the behaviour of others is viewed with anxiety, mistrust or hostility, and perceived as potentially threatening.

MB26.A Suicidal ideation

- Suicidal ideation refers to thoughts, ideas or ruminations about the possibility of ending one's life, ranging from thinking that one would be better off dead to formulation of elaborate plans.

MB26.Y Other specified symptoms or signs involving content of thought

MB26.Z Symptoms or signs involving content of thought, unspecified

MB27 Symptoms or signs involving perceptual disturbance

This grouping includes symptoms or signs involving a disruption in sensory perception, including depersonalization, derealization and hallucinations in any modality.

MB27.0 Depersonalization

- Depersonalization refers to experiencing the self as strange or unreal, feeling detached from it, or the individual feeling as though they were an outside observer of their own thoughts, feelings, sensations, body or actions. Depersonalization may take the form of emotional and/or physical numbing, a sense of watching oneself from a distance or "being in a play", or perceptual alterations (e.g. a distorted sense of time).

MB27.1 Derealization

- Derealization refers to experiencing other people, objects or the world as strange or unreal (e.g. dreamlike, distant, foggy, lifeless, colourless, or visually distorted), or feeling detached from one's surroundings.

MB27.2 Hallucinations

- Hallucinations refer to sensory perceptions of any modality occurring in the absence of the appropriate (external) stimulus. The person may or may not have insight into the unreal nature of the perception. They include the following subcategories.

MB27.20 Auditory hallucinations

- Auditory hallucinations refer to hallucinations involving the perception of sound – most frequently of voices but sometimes of clicks or other noises – that are not restricted to the period of awakening or the onset of sleep.

MB27.21 Gustatory hallucinations

- Gustatory hallucinations refer to hallucinations of taste in the absence of an actual external stimulus.

MB27.22 Hypnopompic hallucinations

- Hypnopompic hallucinations refer to hallucinations that occur during the period of awakening – most commonly of the visual, tactile or auditory modality.

MB27.23 Hypnagogic hallucinations

- Hypnagogic hallucinations refer to hallucinations that occur at the onset of sleep – most commonly of the visual, tactile or auditory modality.

MB27.24 Olfactory hallucinations

- Olfactory hallucinations refer to hallucinations involving the perception of odour (e.g. of burning rubber, decaying fish, orange peel) in the absence of an actual external stimulus.

MB27.25 Somatic hallucinations

- Somatic hallucinations refer to hallucinations involving the perception of an unusual physical state or event within the body, such as an electrical impulse running down the individual's arms or an object inside their chest.

MB27.26 Tactile hallucinations

- Tactile hallucinations refer to hallucinations involving the perception of being touched (e.g. feeling like bugs are crawling on the skin, pins being stuck into one's finger) that are not restricted to the period of awakening or the onset of sleep.

MB27.27 Visual hallucinations

- Visual hallucinations refer to hallucinations involving sight in the absence of an actual visual stimulus that are not restricted to the period of awakening or the onset of sleep, which may involve formed images, such as of people, or unformed images, such as flashes of light. ***Note:*** visual hallucinations must be distinguished from illusions, which are visual misperceptions of real external stimuli.

MB27.2Y	Other specified hallucinations
MB27.2Z	Hallucinations, unspecified
MB27.3	Disturbance of body image

- Disturbance of body image refers to excessively negative, distorted or inaccurate perception of the individual's own body or parts of it.

MB27.4	Illusions

- Illusions refer to misinterpretation of a true sensation (e.g. hearing voices in the sound of running water, the perception of figures in shadows).

MB27.Y	Other specified symptoms or signs of perceptual disturbances
MB27.Z	Symptoms or signs of perceptual disturbance, unspecified

MB28 Symptoms or signs related to personality features

This grouping includes symptoms or signs involving the characteristics or qualities possessed by a person that uniquely influence their cognition, motivations and behaviours in various situations.

MB28.0	Attention seeking

- Attention seeking refers to a tendency to engage in behaviour designed to attract notice and to make oneself the focus of others' attention.

MB28.1	Callousness

- Callousness refers to a lack of concern for the feelings or problems of others, or a lack of guilt or remorse about the negative or harmful effects of one's actions on others.

MB28.2	Eccentricity

- Eccentricity refers to a tendency towards appearance or behaviour that is odd, unusual, peculiar or unconventional, and is inconsistent with cultural or subcultural norms.

MB28.3 Entitlement

- Entitlement refers to a belief that the individual is inherently deserving of privileges or special treatment.

MB28.4 Hostility

- Hostility refers to a tendency to experience persistent or frequent angry feelings – especially in response to minor slights and insults – and to adopt an unfriendly or threatening attitude in interactions with others.

MB28.5 Impulsivity

- Impulsivity refers to a tendency to act on the spur of the moment in response to immediate stimuli, characterized by lack of deliberation and failure to consider risks and consequences before acting. Impulsivity may reflect a desire for immediate rewards or an inability to delay gratification.

MB28.6 Indecisiveness

- Indecisiveness refers to a tendency to have difficulty making decisions or committing to a course of action.

MB28.7 Irresponsibility

- Irresponsibility refers to a pattern of disregard for and failure to honour obligations or commitments, a lack of respect for and follow-through on agreements or promises, or carelessness with others' property.

MB28.8 Low frustration tolerance

- Low frustration tolerance refers to a diminished ability to regulate one's emotions and behaviour in response to frustrating circumstances.

MB28.9 Low self-esteem

- Low self-esteem refers to a low appraisal of the individual's self-worth.

MB28.A Negative affectivity

- Negative affectivity refers to a tendency to experience a broad range of distressing emotions (e.g. anxiety, anger irritability, depression, other negative emotional states), often in response to even relatively minor actual or perceived stressors.

MB28.B Negativism

- Negativism refers to a tendency to oppose or resist suggestions or advice, or to resist stubbornly for no apparent reason.

MB28.C Perfectionism

- Perfectionism refers to an inclination to demand flawlessness of oneself or others and to set excessively high standards.

MB28.D Pessimism

- Pessimism refers to an inclination to emphasize adverse aspects, conditions and possibilities, or to expect the worst possible outcome.

MB28.E Recklessness

- Recklessness refers to a tendency to engage in behaviour that potentially endangers a person's physical health, safety or life.

MB28.F Sensation seeking

- Sensation seeking refers to an inclination to search for experiences and feelings that are varied, novel, complex and intense.

MB28.G Stubbornness

- Stubbornness refers to a steadfast adherence to an opinion, purpose or course of action in spite of reason, arguments or persuasion.

MB28.H Submissiveness

- Submissiveness refers to a tendency to adapt one's behaviour to the actual or perceived interests and desires of others, even when doing so is antithetical to the individual's own interests, needs or desires.

MB28.Y Other specified symptoms or signs related to personality features

MB28.Z Symptoms or signs related to personality features, unspecified

MB29 Symptoms or signs involving eating and related behaviour

This grouping includes symptoms or signs related to disturbances in the regulation or form of eating behaviour that are not developmentally appropriate or culturally sanctioned, including avoidant or restrictive eating, binge eating, decreased appetite, eating of non-nutritive substances, increased appetite, purging behaviour and rumination-regurgitation.

MB29.0 Avoidant or restrictive eating

- Avoidant or restrictive eating refers to acceptance of only a limited diet, which may be defined in terms of a specific dietary composition or sensory features of food, that is inconsistent with cultural or subcultural norms.

MB29.1 Binge eating

- Binge eating refers to an episode in which an individual eats notably more than usual, and feels that they are unable to stop or limit the amount or type of food eaten.

MB29.2 Eating of non-nutritive substances

- Eating of non-nutritive substances refers to consumption of non-food objects and materials (e.g. clay, soil, chalk, plaster, plastic, metal, paper) or raw food ingredients (e.g. large quantities of salt or corn flour).

MB29.3 Purging behaviour

- Purging behaviour refers to behaviour aimed at the removal of ingested food from the body with the specific intention to lose weight or prevent weight gain (e.g. self-induced vomiting, laxative abuse, use of enemas).

MB29.4 Rumination-regurgitation

- Rumination-regurgitation refers to re-chewing of previously swallowed food that has been brought back to the mouth through regurgitation, which may then be re-swallowed or spat out.

MG43.1 Overeating

- Overeating refers to the consumption of excess food in relation to energy and nutritional requirements.

MG43.5 Excessive weight loss

- Excessive weight loss refers to a reduction of total body mass, due to loss of fluid, body fat or adipose tissue, or lean (muscle) mass that is sufficient in quantity or rate to create risk to the individual's health.

MG43.6 Excessive weight gain

- Excessive weight gain refers to an increase in total body mass, due to increase in fluid, fat or adipose tissue, or lean (muscle) mass that is outside the expected range for normal growth and development, and is sufficient in quantity or rate to create risk to the individual's health.

MG43.8 Decreased appetite

- Decreased appetite refers to intermittent or persistent decreased motivation or desire to eat food compared to what is typical for the individual.

MG43.9 Increased appetite

- Increased appetite refers to intermittent or persistent increased motivation or desire to eat food compared to what is typical for the individual.

MB29.Y Other specified symptoms or signs involving eating and related behaviour

MB29.Z Symptoms or signs involving eating and related behaviour, unspecified

MB2A Symptoms or signs involving elimination

This grouping includes symptoms or signs involving the behavioural components of defecation (soiling, faecal elimination) and urination.

MB2A.0 Soiling

- Soiling refers to the passage of faeces in clothing, bed or other inappropriate places in an individual who has reached a developmental age where faecal continence is ordinarily expected.

MB2A.1	Wetting

- Wetting refers to the voiding of urine into clothes or bed, which may occur during the day or night in an individual who has reached a developmental age where urinary continence is ordinarily expected.

MB2A.Y	Other specified symptoms or signs involving elimination
MB2A.Z	Symptoms or signs involving elimination, unspecified
MB2Y	Other specified mental or behavioural symptoms, signs or clinical findings

Relationship problems and maltreatment

Intimate partner and caregiver–child bonds are among the most important factors affecting human health. Threats to these bonds, through acts (e.g. physical maltreatment) or omissions (e.g. neglect), significantly affect physical, mental and social well-being. Mental disorders and other medical conditions can cause, be caused by, exacerbate or be exacerbated by relationship problems or maltreatment. Therefore, accurate diagnosis of relationship problems and maltreatment is important for appropriate treatment planning and care. The coding rules for relationship problems or maltreatment in ICD-11 are complex, and are therefore presented separately in this section.

Different categories from Chapter 23 on external causes of morbidity or mortality and Chapter 24 on factors influencing health status or contact with health services are used to indicate the presence of relationship problems or maltreatment, depending on the purpose of the assessment and the point in time relative to the assessment that maltreatment has occurred or is suspected. Maltreatment is an umbrella term that comprises physical abuse, sexual abuse, psychological abuse and neglect. All categories are applied to the victim of the maltreatment, not to the perpetrator. In cases of mutual relationship distress or maltreatment where both parties in a dyad are being evaluated, the categories may be applied to both. Because relationship distress and different forms of maltreatment (physical, sexual, psychological or neglect) can co-occur, as many of these categories may be assigned together as necessary to describe the relevant clinical phenomena.

ICD-11 uses consistent definitions of maltreatment across these different sets of categories.

- *Physical abuse* (also called physical maltreatment) is defined as non-accidental acts of physical force that result – or have reasonable potential to result – in physical harm, or that evoke significant fear.
- *Sexual abuse* (also called sexual maltreatment) is defined in adults as forced or coerced sexual acts, or sexual acts with someone who is unable to consent. In children, it is defined as sexual acts involving a child that are intended to provide sexual gratification to an adult.
- *Psychological abuse* (also called psychological maltreatment) is defined as non-accidental verbal or symbolic acts that result in significant psychological harm.
- *Neglect* is defined as egregious acts or omissions by a caregiver that deprive a child, or an adult who is incapable of self-care, of needed age-appropriate care, and that result – or have reasonable potential to result – in physical or psychological harm.

Maltreatment as a cause of injury or death

Categories for maltreatment from Chapter 23 on external causes of morbidity or mortality are used when the purpose is to document the cause of an injury being treated or the cause of death. These categories are used along with a classification of the associated physical injury (e.g. fracture of nasal bones, burns of external body surface). Available maltreatment categories in Chapter 23 include:

PJ20 Physical maltreatment

PJ21 Sexual maltreatment

PJ22 Psychological maltreatment

PJ2Y Other specified maltreatment

PJ2Z Maltreatment, unspecified

PJ5B Unintentional neglect

PF1B Assault by neglect

PH7B Neglect with undetermined intent.

The associated injury from Chapter 22 on injury, poisoning or certain other consequences of external causes is postcoordinated with the type of maltreatment presumed to have caused it.

Mental, behavioural and neurodevelopmental disorders such as post-traumatic stress disorder and recurrent depressive disorder can clearly be the result of or be exacerbated by maltreatment, but they are not typically considered immediate causes of the types of injuries classified in Chapter 22. However, mental disorders are provided as postcoordination options for PJ22 Psychological maltreatment. For other maltreatment categories in Chapter 23, any applicable mental, behavioural and neurodevelopmental disorder diagnosis should be assigned separately.

Additional dimensions of the maltreatment as a cause of injury can also be specified via postcoordination. These include activity when injured (e.g. paid work, educational activity), place of occurrence (e.g. home, school, education area), the perpetrator–victim relationship (e.g. spouse or partner, parent, stranger) and the gender of the perpetrator.

As an illustration, below is a fully postcoordinated example of a Chapter 23 maltreatment code:

- PJ20 Physical maltreatment
  - Associated with: NA02.3 Fracture of skull or facial bones
  - Activity when injured: XE9ME Unpaid cleaning, cooking or maintenance at own place of residence
  - Place of occurrence: XE266 Home
  - Perpetrator–victim relationship: XE454 Spouse or partner
  - Gender of perpetrator, male: XE5YG
- Context of assault and maltreatment: XE0UM Altercation

The full postcoordinated code is: PJ20&XE9ME&XE266&XE454&XE5YG&XE0UM/NA02.3.

(See discussion of ICD-11 diagnostic coding, p. 30, in the introductory section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders.)

Relationship problems and maltreatment as factors influencing health status or contact with health services

Categories for relationship problems and maltreatment from Chapter 24 on factors influencing health status or contact with health services are used when the purpose is to record one of three types of clinically significant relationship phenomena. These are:

- to document a pattern of clinically significant relationship conflict with an intimate partner, parent or other caregiver;
- to document a history over the individual's lifetime of maltreatment independent of a specific injury or other harm, which may refer to ongoing maltreatment or to past episodes – such as a history of child abuse – that are relevant to the individual's health status or encounters with the health system; or
- to document a possible episode of maltreatment that is currently under clinical investigation.

Available categories for intimate partner or caregiver–child relationship distress or conflict in Chapter 24 are:

QE51.0 Relationship distress with spouse or partner

Relationship distress with spouse or partner is defined as substantial and sustained dissatisfaction with a spouse or intimate partner associated with significant disturbance in functioning. This diagnosis can be assigned to one or both parties in a dyad, depending on the context of the evaluation or treatment.

QE52.0 Caregiver–child relationship problem

Caregiver–child relationship problem is defined as substantial and sustained dissatisfaction within a caregiver–child relationship, including a parental relationship, associated with significant disturbance in functioning. This diagnosis can be assigned to one or both parties in a dyad, depending on the context of the evaluation or treatment.

Available categories for history of maltreatment in Chapter 24 are:

QE51.1 History of spouse or partner violence

QE51.10	History of spouse or partner violence, physical
QE51.11	History of spouse or partner violence, psychological
QE51.12	History of spouse or partner violence, sexual
QE51.13	History of spouse or partner violence, neglect.

These diagnoses can be used to indicate ongoing or past episodes of maltreatment by a spouse or partner when the focus of the evaluation is not related to a specific injury or death. If the history of maltreatment is not related to a spouse or partner relationship, categories from QE82 Personal history of maltreatment should be used instead.

QE82 Personal history of maltreatment

QE82.0	Personal history of physical abuse
QE82.1	Personal history of sexual abuse
QE82.2	Personal history of psychological abuse
QE82.3	Personal history of neglect
QE82.Y	Other specified personal history of maltreatment
QE82.Z	Personal history of maltreatment, unspecified.

These diagnoses can be used to indicate ongoing or past episodes of maltreatment by someone other than a spouse or partner (e.g. a parent, another relative, a stranger), when the focus of the evaluation is not related to a specific injury or death. If the history of maltreatment is related to a spouse or partner relationship, categories from QE51.1 History of spouse or partner violence should be used instead. The time in life (e.g. child under 5 years, adolescent, late geriatric) can be indicated using postcoordinated extension codes.

Available categories for examination or observation for suspected maltreatment in Chapter 24 are:

QA04.5 Examination or observation for suspected maltreatment

QA04.50	Examination or observation for suspected physical maltreatment
QA04.51	Examination or observation for suspected sexual maltreatment
QA04.52	Examination or observation for suspected psychological maltreatment
QA04.53	Examination or observation for suspected neglect or abandonment
QA04.5Y	Other specified examination or observation for suspected maltreatment
QA04.5Z	Examination or observation for suspected maltreatment, unspecified.

If maltreatment is confirmed based on the examination or observation, the diagnosis should generally be changed to one of the maltreatment categories in Chapter 24, if the evaluation is in relation to a specific injury, or otherwise to the applicable history or spouse or partner violence or personal history of maltreatment category in Chapter 24.

In some circumstances, categories from Chapter 23 and Chapter 24 can be used together – for example, when there is an established history of maltreatment, and an injury resulting from that maltreatment is the focus of a current episode of care. However, examination or observation codes in Chapter 24 would typically not be assigned together with maltreatment categories from Chapter 23 explaining the cause of a specific injury.

As an illustration, below is a postcoordinated example of a Chapter 23 maltreatment code:

- QE82.1 Personal history of sexual abuse
- Time in life: XT7Q Early adolescence.

The postcoordinated code is: QE82.1&XT7Q.

(See discussion of ICD-11 diagnostic coding, p. 30, in the introductory section on using the CDDR for ICD-11 mental, behavioural and neurodevelopmental disorders.)

CDDR for common forms of relationship problems and maltreatment

Because of their importance and prevalence, CDDR have been developed for two sets of phenomena:

- relationship distress and current or past maltreatment by spouse or partner;
- problems in relationship between child and current or former caregiver, and current or past child maltreatment.

These are among the most clinically important and impactful forms of relationship problems and maltreatment. The CDDR for these two groupings should be applied as appropriate in the context of the ICD-11 coding options for relationship problems and maltreatment. For example, physical abuse by an intimate partner could be classified as PJ20 Physical maltreatment from Chapter 23 or QE51.1 History of spouse or partner violence from Chapter 24, depending on the purpose of the assessment and nature of the situation.

Relationship distress and current or past maltreatment by spouse or partner

This section provides CDDR for the following categories:

- to document the cause of an injury being treated or the cause of death:

  PJ20 Physical maltreatment, spouse or partner
  PJ21 Sexual maltreatment, spouse or partner
  PJ22 Psychological maltreatment, spouse of partner
  PF1B Assault by neglect

- to document a pattern of either a clinically significant relationship conflict with a spouse or intimate partner, or a history of intimate partner maltreatment – including ongoing or past episodes – as factors that are relevant to the individual's health status and encounters with health services rather than in relationship to a specific injury or death:

QE51.0 Relationship distress with spouse or partner

QE51.1 History of spouse or partner violence

QE51.10 History of spouse or partner violence, physical
QE51.12 History of spouse or partner violence, sexual
QE51.11 History of spouse or partner violence, psychological
QE51.13 History of spouse or partner violence, neglect.

Relationship distress with spouse or partner and different forms of intimate partner maltreatment can co-occur. As many of the categories in this section may be assigned together as necessary to describe the relevant clinical phenomena.

General cultural considerations for relationship distress and maltreatment by spouse or partner

- Presentations of relationship distress vary, depending on cultural constraints on their expression. In some cultures, women may be more attentive to relationship problems and therefore more likely report relationship distress.
- The prevalence of the different forms of spouse or partner maltreatment (e.g. physical, sexual, psychological) vary widely by country, based on the social acceptance, detection and consequences of abusive behaviours.

General sex- and/or gender-related features for relationship distress and maltreatment by spouse or partner

- Although men and women are both affected by relationship distress, women's health may be more influenced by relationship distress, whereas men's health may be more influenced by relationship status (i.e. being in an intimate partner relationship or not).
- Gender differences are country- and culture-specific. Overall, women are at much higher risk of victimization by maltreatment by their spouses or intimate partners.

QE51.0 Relationship distress with spouse or partner

Essential (required) features

- Substantial and sustained dissatisfaction with the intimate relationship (e.g. pervasive unhappiness with the relationship, significant thoughts of divorce/separation) is required for diagnosis.
- The dissatisfaction is associated with disturbance in at least one major area of functioning such as:
  - behaviour (e.g. persistent and intense conflicts, pervasive withdrawal or neglect, lack of positive behaviours);

- cognition (e.g. pervasive negative attributions of partner's intent);
- emotion (e.g. persistent and intense anger, sadness or apathy);
- physical health (e.g. pain and other physical symptoms not fully explained by a medical condition);
- interpersonal interaction (e.g. social isolation, decreased involvement in social activities);
- major life role activities (e.g. work, school, caregiving).

Note: this category is assigned to the individual being evaluated. In situations in which a couple is being evaluated, it may be assigned to both parties if applicable.

Additional clinical features

- Relationship distress with spouse or partner is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, disorders due to substance use), and risk of exacerbation of existing medical conditions.

Boundary with normality (threshold)

- Occasional relationship dissatisfaction and disagreements occur in most relationships. Relationship distress with a spouse or partner should only be assigned when relationship dissatisfaction or conflict is a pervasive pattern affecting the individual's functioning in at least one major area.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with spouse or partner maltreatment (physical, psychological, sexual, or neglect)

Relationship distress with spouse or partner is not considered a form of maltreatment. However, if all diagnostic requirements are met for both relationship distress with spouse or partner and a maltreatment category, both may be assigned.

PJ20 / QE51.10 Physical maltreatment, spouse or partner, or history of spouse or partner violence, physical

Essential (required) features

- At least one non-accidental act of physical force (e.g. pushing or shoving, scratching, slapping, throwing something that could cause injury, punching, biting) is required for diagnosis.
- The act causes (or exacerbates) at least one of the following:
  - any physical injury;
  - significant fear;
  - reasonable potential for significant physical injury.
- The act was not for physical protection of the individual (e.g. to ward off a partner's punches) or partner (e.g. to prevent a partner from attempting suicide).

Note: these categories are assigned to the victim, not the perpetrator. In cases of mutual violence in which the couple is being evaluated, they may be assigned to both parties if applicable.

If PJ20 Physical maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ20&XE454). On the ICD-11 platform, the option to specify the perpetrator–victim relationship appears in the context of the assault field.

Additional clinical features

- Intimate partner physical abuse is, by definition, associated with an increased risk of physical injury and need for medical attention.
- Intimate partner physical abuse is associated with an increased risk of poor physical health and the development of a chronic disease.
- Intimate partner physical abuse is associated with higher rates of depressive disorders, post-traumatic stress disorder and disorders due to substance use, as well as suicidality.
- A pattern of recurrent acts, or the intent to assert control or power, are not required features for assigning a diagnosis of intimate partner physical abuse. The diagnosis only requires at least one act of violence that causes or exacerbates at least one negative impact.
- Most children (i.e. approximately 75%) living in households with clinically significant intimate partner physical abuse witness it. Exposure to parental or caregiver intimate partner violence places children at significantly greater risk of a range of mental disorders, negative affect/distress and negative cognitions, as well as social and academic difficulties.

Boundary with normality (threshold)

- Acts of physical aggression (e.g. grabbing a partner's arm) that do not cause injury or significant fear are relatively common in intimate relationships. In contrast, the acts of physical violence and associated impacts characteristic of intimate partner physical abuse are not part of healthy functioning relationships.

Course features

- Intimate partner physical abuse may lessen and remit over time. However, for many affected relationships, intimate partner physical abuse reoccurs and sometimes increases in frequency or severity.
- The risk of intimate partner physical abuse increases in the context of external stressors (e.g. job loss) or when the victim is disabled.

Developmental presentations

- In general, adolescents and young adults are at greater risk of being victims of intimate partner physical abuse because the rate of physically violent acts against intimate partners among perpetrators tends to decrease across the lifespan.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with relationship distress with spouse or partner

Intimate partner physical abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned.

PJ21/ QE51.12 Sexual maltreatment, spouse or partner, or history of spouse or partner violence, sexual

Essential (required) features

- At least one of the following acts is required for diagnosis:
  - the use of physical force to compel participation in a sex act against the partner's will, or when the partner is incapable of consent (whether or not the act is completed);
  - the use of physical or psychological aggression to coerce the partner to participate in a sex act.
- The act is against the expressed wishes of the partner.
- The act causes significant distress to the partner.

Note: these categories are assigned to the victim, not the perpetrator.

If PJ21 Sexual maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ21&XE454). On the ICD-11 platform, the option to specify the perpetrator–victim relationship appears in the context of the assault field.

Additional clinical features

- Intimate partner sexual abuse is associated with an increased risk of physical injury and need for medical attention.
- Intimate partner sexual abuse is associated with an increased risk of poor physical health and of development of a chronic disease.
- Intimate partner sexual abuse is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, disorders due to substance use), as well as suicidality.

Boundary with normality (threshold)

- Sexual violation and coercion are not part of healthy functioning relationships.

Developmental presentations

- In general, adolescents and young adults are at greater risk of being victims of intimate partner sexual abuse because the rate of sexually abusive acts among perpetrators tends to decrease across the lifespan.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with relationship distress with spouse or partner

Intimate partner sexual abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned.

PJ22/ QE51.11 Psychological maltreatment, spouse or partner, or history of spouse or partner violence, psychological

Essential (required) features

- Verbal or symbolic acts with the potential to cause psychological harm to the victim are required for diagnosis, such as:
  - berating, disparaging, degrading, humiliating the partner;
  - interrogating the partner;
  - restricting the partner's ability to come and go freely;
  - obstructing the partner's access to assistance (e.g. police aid, legal help, protective resources, medical resources, mental health resources);
  - threatening the partner;
  - harming, or threatening to harm, people/things that the partner cares about;
  - restricting the partner's access to or use of economic resources;
  - isolating the partner from family, friends or social support resources;
  - stalking the partner;
  - trying to make people think that the partner is "crazy", including for suggesting that they are a victim of psychological maltreatment.
- The acts cause (or exacerbate) at least one of the following:
  - significant fear;
  - significant psychological distress;
  - somatic symptoms that interfere with normal functioning;

- significant self-imposed restrictions in engaging in one or more major life activities (e.g. work, education, religion, medical or mental services, contact with family members) to avoid recurrence of the acts.

Note: these categories are assigned to the victim, not the perpetrator.

If PJ22 Psychological maltreatment is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PJ22&XE454). On the ICD-11 platform, the option to specify the perpetrator–victim relationship appears in the context of the assault field.

Additional clinical features

- Intimate partner psychological abuse typically represents a pattern of behaviours. However, it may be diagnosed based on a single episode if it is sufficiently impactful (e.g. harming a pet to punish the partner).
- Intimate partner psychological abuse at a clinically significant level is associated with increased risk of seeking medical attention, as well as an increased risk of poor health and of development of a chronic disease.
- Intimate partner psychological abuse is associated with higher rates of depressive disorders, post-traumatic stress disorder and disorders due to substance use, as well as suicidality.

Boundary with normality (threshold)

- Acts of psychological aggression (e.g. disparaging one's partner) that do not cause significant distress are relatively common in intimate relationships. In contrast, the verbal and symbolic acts and their associated impacts that constitute intimate partner psychological abuse are not characteristic of healthy functioning relationships.

Course features

- Intimate partner psychological abuse commonly emerges in adolescence and early adulthood, but is prevalent across the lifespan.
- The risk of intimate partner psychological abuse increases in the context of external stressors (e.g. job loss).

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with relationship distress with spouse or partner

Intimate partner psychological abuse may be, but is not always, associated with relationship distress with spouse or partner. If all diagnostic requirements are met for both relationship distress with spouse or partner and maltreatment or history of spouse or partner violence, both may be assigned.

PF1B / QE51.13 Assault by neglect or history of spouse or partner violence, neglect

Essential (required) features

- At least one egregious act or omission by an adult's caregiver that deprives an intimate partner who is incapable of self-care of needed or adequate food, shelter, hygiene or necessary services is required for diagnosis. Examples of self-care incapacity include physical, psychological, intellectual and cultural (e.g. inability to manage activities of rudimentary daily living due to living in a foreign culture) limitations.
- The act or omission causes significant physical injury or other significant negative consequences to health (e.g. development of an illness directly linked to the neglect, malnutrition) or reasonable potential for significant injury or negative consequences to health.

Note: this category is assigned to the victim, not the perpetrator.

If PF1B Assault by neglect is diagnosed, the perpetrator should be specified as a spouse or partner using the extension code XE454 (PF1B&XE454). On the ICD-11 platform, the option to specify the perpetrator–victim relationship appears in the context of the assault field. Depending on the specific situation, PB5B Unintentional neglect or PH7B Neglect with undetermined intent may be diagnosed rather than PF1B Assault by neglect.

Additional clinical features

- Neglect at a clinically significant level is associated with increased risk of various mental disorders (e.g. depressive disorders, anxiety and fear-related disorders, post-traumatic stress disorder), suicidality and various medical conditions (e.g. bed sores, malnutrition).

Boundary with normality (threshold)

- Small lapses in caregiving to partners who are incapable of self-care are common, and a diagnosis of history of spouse or partner violence, neglect, should not be assigned on this basis. In contrast, egregious acts or omissions that cause significant physical injury or reasonable potential for such injury much less common and, if all diagnostic requirements are met, warrant the diagnosis.

Problems in relationship between child and current or former caregiver and current or past child maltreatment

This section provides CDDR for the following categories:

- to document the cause of an injury being treated or the cause of death:

  PJ20 Physical maltreatment of a child

  PJ21 Sexual maltreatment of a child

  PJ22 Psychological maltreatment of a child

  PF1B Assault by neglect

- to document a pattern of either a clinically significant relationship conflict in the relationship of a child with a current or former caregiver, or a history of child maltreatment – including ongoing or past episodes – as factors that are relevant to the individual's health status and encounters with health services rather than in relationship to a specific injury or death:

  QE52.0 Caregiver–child relationship problem

  QE82.0 Personal history of physical abuse as a child

  QE82.1 Personal history of sexual abuse as a child

  QE82.2 Personal history of psychological abuse as a child

  QE82.3 Personal history of neglect as a child.

Caregiver–child relationship problem and different forms of child maltreatment may co-occur. As many of the categories in this section may be assigned together as necessary to describe the relevant clinical phenomena.

QE52.0 Caregiver–child relationship problem

Essential (required) features

- Substantial and sustained dissatisfaction with the caregiver–child relationship (including adolescents) is required for diagnosis; this may be manifested in:
  - a pervasive sense of unhappiness with the relationship;
  - for the child, repeated running away, persistent thoughts of running away or fantasies of having another caregiver;
  - for the caregiver, wishing the child were totally different or had not been born, or thoughts of relinquishing care of the child;
  - the child allying themselves strongly with one parent and rejecting a relationship with the other parent, without evidence of maltreatment by the rejected parent – this primarily occurs in the context of a high-conflict relationship between two parents, including separation or divorce.
- The dissatisfaction is associated with disturbance in at least one major area of functioning, such as the following:
  - behaviour (e.g. persistent and intense conflicts, pervasive withdrawal or neglect; lack of positive behaviours; failure to socialize child through nonexistent or poorly enforced limits; poor monitoring of the child's activities; overinvolvement in child's activities; child concealment of activities; child's persistent rejection, denigration and criticism of the caregiver);
  - cognition (e.g. pervasive negative attributions of caregiver or child intent);
  - emotion (e.g. persistent and intense anger, contempt, sadness or apathy);
  - physical health (i.e. exacerbation of medical or psychological symptoms or significant interference with provision of medical or psychological care);
  - interpersonal interaction (e.g. social isolation, decreased involvement in social activities);
  - major life role activities (e.g. work, school, caregiving).

Note: behaviours associated with each area will vary according to the developmental stage of the child or adolescent, as well as the cultural context. This category should only be considered as applicable within a child or adolescent's primary caregiving relationships, which may include relationships with parents, grandparents or other significant long-term caregivers. This category may be assigned to either the child or the caregiver, depending on who is being evaluated. In situations in which a caregiver–child dyad is being evaluated, substantial and sustained relationship dissatisfaction, if present, is commonly – although not always – experienced by both parties. The diagnosis may be assigned to both parties if applicable.

Additional clinical features

- Problems in caregiver–child relationships are associated with the development of oppositional defiant disorder and conduct-dissocial disorder.

Boundary with normality (threshold)

- Temporary fluctuations in parenting behaviours due to stress or illness are common. For example, a parent undergoing serious medical treatment may be unable temporarily to meet a child's needs appropriately. Similarly, more focused conflicts with caregivers are common among adolescents. Caregiver–child relationship problem should only be assigned if the relationship distress is substantial and sustained, and affects functioning.

Course features

- Caregiver–child relationship problem has a variable course. In some cases, relationship distress has a chronic course; in other cases, it may show substantial improvement over time.

Developmental presentations

- Young children are more likely to present with attachment problems (insecure or disorganized patterns), difficulty separating from parents or caregivers, or physical complaints than psychological symptoms. Psychological symptoms are more likely among older children and adolescents.
- In infants or young children, distress may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. Significant impact may be evidenced by a lack of appropriate developmental progression or even a loss of skills in an infant or young child.
- For children or teens, distress may be exhibited by physical aggression, poor cooperation or oppositional behaviour with the affected caregiver, or by refusal to interact with the affected caregiver.
- Older caregivers, such as grandparents, may be more vulnerable to problems in their relationships with high-energy children.

Sex- and/or gender-related features

- Although both the nature of the parental acts and their impact can vary by gender, boys and girls are equally likely to experience a caregiver–child relationship problem.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with child maltreatment (physical abuse, sexual abuse, psychological abuse, neglect)

Caregiver–child relationship problem includes parenting behaviours that are within the normal range given the sociocultural context but that nonetheless have a negative impact on the child. Some caregiving behaviours may be appropriate for many children, but not for the specific child. These caregiver behaviours do not meet the diagnostic requirements for any child maltreatment category. In contrast, in child psychological maltreatment, one or more verbal or symbolic acts of parenting are clearly outside cultural norms, and are – or have reasonable potential to be – harmful to the child. If diagnostic requirements for both caregiver–child relationship problem and a form of child maltreatment are met, both may be assigned.

Boundary with oppositional defiant disorder

Oppositional defiant disorder is characterized by a pattern of markedly noncompliant, defiant and disobedient disruptive behaviour that is not typical for individuals of comparable age and developmental level. Similar behaviours may be observed in the context of caregiver–child relationship problem, but these are often confined to the specific caregiver–child relationship. In addition, in caregiver–child relationship problem there is often evidence that caregiver behaviours are not optimal for the child. However, if diagnostic requirements for both caregiver–child relationship problem and oppositional defiant disorder are met, both may be assigned.

Boundary with reactive attachment disorder and disinhibited social engagement disorder

Reactive attachment disorder and disinhibited social engagement disorder are characterized by a history of grossly insufficient care associated with markedly abnormal attachment behaviours exhibited towards adult caregivers, with onset prior to the age of 5 years. Similar abnormal attachment behaviours may be observed in caregiver–child relationship problem. However, if all diagnostic requirements for reactive attachment disorder or disinhibited social engagement disorder are met, a diagnosis of caregiver–child relationship problem is typically not warranted.

PJ20 / QE82.0 Physical maltreatment of child or personal history of physical abuse as a child

Essential (required) features

- At least one non-accidental act of physical force (e.g. pushing or shoving, slapping, punching, throwing something that could cause injury) towards a child or adolescent is required for diagnosis.

- The act causes (or exacerbates) at least one of the following:
  - any physical injury (e.g. bruises, cuts, sprains, broken bones, loss of consciousness, pain that lasts for several hours);
  - significant fear;
  - reasonable potential for significant physical injury.
- The act was not committed for physical self-protection (e.g. to ward off an adolescent's punches) or to protect the child or adolescent (e.g. to prevent a small child from running into a busy street or to prevent an adolescent from attempting suicide).

Note: these categories are assigned to the victim, not the perpetrator.

If PJ20 Physical maltreatment is diagnosed, the perpetrator–victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Similarly, if QE82.0 Personal history of physical abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided.

Additional clinical features

- Physical abuse of a child or adolescent can occur as an isolated incident. However, it can also occur as a pattern of parental or caregiver behaviour. If identified in a child or adolescent, it is important to evaluate whether past injuries were due to child physical abuse.
- There are numerous injury types that when presented in a child are likely to have been caused by physical abuse. These include classic metaphyseal lesion (bucket handle fracture of the long bone); femur – metaphyseal and spiral fractures; humerus – metaphyseal and spiral fractures; rib fractures; spinous process fracture; skull – diastatic, across suture lines; subdural/epidural injury; patterned burns; patterned bruising; retinal haemorrhage (bilateral, multilayer). Many other injuries may also be caused by physical abuse of a child.
- Child physical abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality.
- Among younger children, disturbances in attachment, difficulty separating from parents or caregivers and vague physical complaints (stomach pain, headache) are more common results of physical abuse than psychological symptoms.

Boundary with normality (threshold)

- Physical discipline (e.g. spanking following perceived negative behaviours of the child) does not necessarily meet the diagnostic requirements for child physical abuse. Physical discipline is differentiated from child physical abuse by its impact. If physical discipline results in injury, has a reasonable potential for causing physical injury or elicits significant fear, a diagnosis of child physical abuse may be warranted.

Developmental presentations

- For infants or young children, distress associated with physical abuse may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. The child may also exhibit an insecure or disorganized pattern of attachment. A significant impact of physical abuse may be evidenced by lack of appropriate developmental progression or even a loss of skills in infant or young child. Vague physical complaints (stomach pain, headache) are also common.
- Symptoms of mental disorders are more likely among older children and adolescents who experience physical abuse. Distress may also be manifested in physical aggression, poor cooperation or oppositional behaviour towards the relevant caregiver; refusal to interact with that caregiver; thoughts of running away or fantasies of having another caregiver; inhibition, withdrawal or low self-esteem.

Sex- and/or gender-related features

- Although the impact of physical abuse can vary by gender (e.g. externalizing versus internalizing symptoms), boys and girls are equally likely to be victims.

PJ21/ QE82.1 Sexual maltreatment of child or personal history of sexual abuse as child

Essential (required) features

- At least one of the following acts involving an adult and a child is required for diagnosis:
  - physical contact of a sexual nature between child and an adult – for example, vaginal or anal penetration (or attempted penetration), oral-genital or oral-anal contact, fondling (directly or through clothing);
  - non-contact exploitation, involving an adult forcing, tricking, enticing, threatening or pressuring a child to participate in acts for anyone's sexual gratification without direct physical contact between the child and the perpetrator – for example, exposing a child's genitals, anus or breasts; having a child masturbate or watch masturbation; having a child participate in sexual activity with a third person (including child prostitution); having a child pose, undress or perform in a sexual fashion (including child pornography).

Note: these categories are assigned to the victim, not the perpetrator.

If PJ21 Sexual maltreatment is diagnosed, the perpetrator–victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform

in the context of the assault field. Similarly, if QE82.1 Personal history of sexual abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided.

Additional clinical features

- Child sexual abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality.
- Sexual abuse that includes physical contact and penetration can result in genital or anal injuries, sexually transmitted diseases and pregnancy.

Boundary with normality (threshold)

- Mutual sex play between age mates is not considered sexual abuse. Sexual activity between adolescent partners should not be diagnosed as child sexual abuse.

Developmental presentations

- Among younger children who experience sexual abuse, disturbances in attachment (insecure or disorganized patterns, difficulty separating from parents or caregivers, and vague physical complaints such as stomach pain or headache) are more common than psychological symptoms.
- Among older children and adolescents, psychological symptoms and externalizing behaviours are more common reactions to sexual abuse.

Sex- and/or gender-related features

- Sexual abuse of girls is generally more common than sexual abuse of boys, although this varies by country and culture.

PJ22 / QE82.2 Psychological maltreatment of child or personal history of psychological abuse as child

Essential (required) features

- Verbal or symbolic acts with the potential to cause psychological harm to a child or adolescent are required for diagnosis. Examples include:
  - berating, disparaging, degrading, humiliating the child;
  - threatening the child (e.g. indicating or implying future physical harm, abandonment, sexual assault);
  - harming or abandoning – or threatening to harm or abandon – people or things that the child cares about, such as pets, property, loved ones (e.g. exposing a child to spouse or partner maltreatment);
  - confining the child (e.g. typing a child's arms or legs together; binding a child to a chair, bed or other object; confining a child to an small enclosed area such as a closet);
  - scapegoating the child (i.e. blaming child for things for which they cannot possibly be responsible);
  - coercing the child to inflict pain on themselves;
  - disciplining the child excessively through physical or non-physical means (e.g. extremely high frequency or duration), without necessarily meeting diagnostic requirements for physical maltreatment.
- The acts cause (or exacerbate) at least one of the following:
  - significant fear;
  - significant psychological distress;
  - somatic symptoms that interfere with normal functioning;
  - significant avoidance or reluctance to engage in one or more major life activities (e.g. work, education, religion, medical or mental services, contact with family members) to avoid recurrence of the acts.

Note: these categories are assigned to the victim, not the perpetrator.

If PJ22 Psychological maltreatment is diagnosed, the perpetrator–victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Similarly, if QE82.2 Personal history of psychological abuse is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided.

Additional clinical features

- Child psychological abuse typically represents a pattern of parental or caregiver behaviours. However, it may be diagnosed based on single episode if it is sufficiently impactful (e.g. harming a pet to punish the child).

- Child psychological abuse is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder and conduct-dissocial disorder, as well as attentional problems, academic problems and suicidality.

Boundary with normality (threshold)

- Child psychological abuse is characterized by one or more verbal or symbolic acts, generally outside the sociocultural norms for parenting, that are – or have reasonable potential to be – harmful to the child. In contrast, whereas normal discipline may be upsetting to children, unlike psychological maltreatment it does not cause psychological harm, have the potential to cause psychological harm, result in somatic symptoms or interfere with functioning.

Developmental presentations

- For infants or young children, distress associated with psychological abuse may be exhibited by persistent withdrawal from the caregiver, freezing behaviours or heightened reactivity around the caregiver. The child may also exhibit an insecure or disorganized pattern of attachment. A significant impact of psychological abuse may be evidenced by lack of appropriate developmental progression or even a loss of skills in infant or young child. Vague physical complaints (stomach pain, headache) are also common.
- Symptoms of mental disorders are more likely among older children and adolescents who experience psychological abuse. Distress may also be manifested in physical aggression, poor cooperation or oppositional behaviour towards the relevant caregiver; refusal to interact with that caregiver; thoughts of running away or fantasies of having another caregiver; inhibition, withdrawal or low self-esteem.

Sex- and/or gender-related features

- Although the nature of parental acts (e.g. restriction versus humiliation) and the impact of psychological abuse can vary by gender, boys and girls are equally likely to be victims.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with caregiver–child relationship problem

Psychological maltreatment should be distinguished from caregiver–child relationship problem, which – unlike psychological maltreatment – is characterized by parenting behaviours that are within the normal range for the sociocultural context but may still have a negative impact on the child.

PF1B / QE82.3 Assault by neglect or personal history of neglect as a child

Essential (required) features

- At least one confirmed or suspected egregious act or omission by a child or adolescent's caregiver that deprives the child of needed age-appropriate care is required for diagnosis (e.g. abandonment, lack of appropriate supervision; exposure to physical hazard; failure to provide necessary education, health care, nourishment, shelter, clothing).
- The act or omission causes or exacerbates at least one of the following impacts:
  - significant physical injury or reasonable potential for significant injury;
  - other significant negative consequences to health (e.g. development of an illness directly linked to the neglect, malnutrition) or reasonable potential for significant negative consequences to health;
  - significant fear or psychological distress;
  - reasonable potential for significant psychological harm (e.g. development of a mental disorder) or for significant disruption of the child's physical, psychological, cognitive or social development);
  - somatic symptoms that interfere with normal functioning.

Note: this category is assigned to the victim, not the perpetrator.

If PF1B Assault by neglect is diagnosed, the perpetrator–victim relationship (e.g. parent, other relative, stranger) should be specified using the extension codes provided on the ICD-11 platform in the context of the assault field. Perpetrator should be specified as a parent, other relative, unrelated caregiver, or official or legal authority using the available extension codes. Depending on the specific situation, PB5B Unintentional neglect or PH7B Neglect with undetermined intent may be diagnosed rather than PF1B Assault by neglect. If QE82.3 Personal history of neglect is diagnosed, the time of life for current or past episodes (e.g. child aged under 5 years, early adolescence) can be specified using the extension codes provided.

Additional clinical features

- Victims of child neglect can present with severe (chronically untreated) dental caries, ear infections or other typical childhood illnesses.
- Child neglect is associated with a variety of mental disorders, including depressive disorders, adjustment disorder, anxiety and fear-related disorders, post-traumatic stress disorder, oppositional defiant disorder, conduct-dissocial disorder, attentional problems, academic problems and suicidality.

Boundary with normality (threshold)

- Parents or other caregivers may provide less than optimal care for their children for brief periods due to caregiver illness or stress. However, normal caregiving requires that they make other arrangements if their own caregiving will be compromised for more than a brief period. If a child is in danger, or is suffering significant harm as a result of inadequate caregiving, the omissions in caregiving should be diagnosed as neglect.

Developmental presentations

- Children of any age can experience neglect. Neglected children may appear mature for their age, but may also exhibit stunted growth due to lack of adequate nutrition or other developmental deficits.
- Failure to meet developmental milestones can be a marker of neglect, as can attachment problems (insecure or disorganized patterns), difficulty separating from parents or caregivers, social skills deficits, behaviour problems and scholastic problems.

Course features

- Although one incident is sufficient to meet the diagnostic requirements, incidents of child neglect often occur as part of a persistent pattern, which substantially increases the risk of mental disorders, medical conditions and disrupted development.

Sex- and/or gender-related features

- Although its impact can vary by gender, boys and girls are equally likely to be victims of neglect.

Boundaries with other disorders and conditions (differential diagnosis)

Boundary with caregiver–child relationship problem

Neglect is characterized by egregious acts or omissions that result in – or have significant potential to result in – negative impacts. A diagnosis of caregiver–child relationship problem is generally more appropriate for children of caregivers who are emotionally neglectful (e.g. not engaging in positive interactions with the child) but have not committed egregious acts or omissions that deprive the child or adolescent of age-appropriate care.

Boundary with reactive attachment disorder and disinhibited social engagement disorder

Both reactive attachment disorder and disinhibited social engagement disorder are considered to result from a history of grossly insufficient care in early childhood, including persistent disregard for the child's basic emotional or physical needs. They can occur in the context of repeated changes of foster care or rearing in institutional settings that prevent the formation of stable selective attachments, as well as in dyadic caregiver relationships. The insufficient care would meet the diagnostic requirements for neglect and possibly also for other forms of maltreatment. Both reactive attachment disorder and disinhibited social engagement disorder are characterized by markedly abnormal attachment behaviours towards adult caregivers that are evident by the age of 5 years. In reactive attachment disorder, there is a persistent and pervasive pattern of inhibited, emotionally withdrawn behaviour, including minimal seeking of comfort when distressed and rare or minimal response to comfort when it is offered. In disinhibited social engagement disorder, there is a persistent and pervasive pattern of markedly abnormal social behaviours, in which the child displays reduced or absent reticence in approaching and interacting with unfamiliar adults. If the diagnostic requirements are met for reactive attachment disorder or disinhibited social engagement disorder, that diagnosis should be assigned. An additional diagnosis of assault by neglect or personal history of neglect may be assigned if it is relevant to the particular clinical situation.

Factors influencing health status or contact with health services particularly relevant to mental health services

This section includes a selection of categories from Chapter 24 on factors influencing health status or contact with health services that may be especially relevant to mental health professionals and mental health services, but that do not represent mental disorders or a disease or disorder classified elsewhere in ICD-11. This listing is not comprehensive, and other available Chapter 24 groupings may be relevant.[6] This listing is also not intended to suggest that these are the only categories from Chapter 24 that should be used by mental health professionals.

One set of categories in Chapter 24 makes it possible to record the reason for a particular health service encounter other than a disease, a disorder or a specific symptom. For example, QE51.0 Relationship distress with spouse or partner is included in this section and is discussed in the section on relationship problems and maltreatment (p. 707). Other examples include QE62 Uncomplicated bereavement and QD3Z Concerns about body appearance that do not meet the diagnostic requirements for body dysmorphic disorder or another mental disorder. These categories can be used on their own without an accompanying disorder diagnosis to describe the reason for a health encounter. For example, a person with no mental disorder diagnosis might present with QD85 Burnout, a syndrome resulting from chronic workplace stress that has not been successfully managed but that is not considered a mental disorder. These categories can also be used in conjunction with a diagnosis from this mental, behavioural and neurodevelopmental disorders chapter to highlight an issue for other health professionals or for the health system. For example, for an individual diagnosed with 6A20.10 Schizophrenia, multiple episodes, currently symptomatic, QE70.0 Inadequate family support could also be coded if it is relevant for discharge planning. Chapter 24 also includes problems related to health behaviours that do not represent diagnosable mental disorders, such as QE10 Hazardous alcohol use or QE23 Problems with inappropriate diet or eating habits.

A second set of categories in Chapter 24 are those that document health services involving different types of counselling that may be provided to individuals living with a mental disorder but also to individuals with no diagnosis. Examples include QA15 Counselling related to sexuality and QA18 Family counselling. These can also be considered interventions or procedures, but they are included in Chapter 24 because they may represent reasons for a particular health encounter.

A third set of categories in Chapter 24 represent broader factors that influence the person's health status and care but are not mental disorders (e.g. QD71.0 Homelessness). Inclusion of this type of category in addition to the diagnosis of a mental disorder can provide important contextual information to improve the personalization of care. For example, QE04 Target of perceived adverse discrimination or persecution could be coded when the experience of racial discrimination is deemed a contributory factor to a depressive disorder. Many of these categories

6 A complete listing can be found at ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who.int/browse11/l-m/en#/).

relate to recognized social determinants of mental health – that is, risk factors for the development, maintenance or moderation of symptoms of mental disorders across the lifespan.

The categories in this list are ordered in a way that is intended to make the list useful to mental health professionals and does not correspond entirely to their ordering in ICD-11.[7] Not all of the categories include brief descriptions or definitions; where they are provided, they are included in this section.

Reasons for contact with mental health services

Problems associated with relationships

(See the section on relationship problems and maltreatment, p. 707.)

QE51 Problems associated with interactions with spouse or partner

QE51.0 Relationship distress with spouse or partner

QE51.1 History of spouse or partner violence

QE52 Problems associated with interpersonal interactions in childhood

QE52.0 Caregiver–child relationship problem

QE52.1 Loss of love relationship in childhood

- Loss of love relationship in childhood refers to the loss of an emotionally close relationship, such as of a parent, a sibling, a very special friend or a loved pet, by death or permanent departure or rejection.

7 See ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who.int/browse11/l-m/en#/).

QE50	Problems associated with interpersonal interactions

Note: relationship distress with spouse or partner and caregiver–child relationship problem should be documented using the categories provided in the section on relationship problems and maltreatment (p. 707).

QE50.0	Problem associated with relationship with friend
QE50.1	Problem associated with relationship with teachers or classmates
QE50.2	Problem associated with relationship with people at work
QE50.3	Problem associated with relationship with neighbours, tenant or landlord
QE50.4	Problem associated with relationship with parents, in-laws or other family members
QE50.5	Discord with counsellors
QE50.6	Inadequate social skills
QE5Y	Other specified problems associated with relationships
QE5Z	Problems associated with relationships, unspecified

Problems associated with absence, loss or death of others

QE60	Absence of family member
QE61	Disappearance or death of family member
QE61.0	Loss or death of child
QE61.Y	Disappearance or death of other family member

QE62	Uncomplicated bereavement

Note: uncomplicated bereavement refers to grief reactions experienced following the disappearance or death of a loved one. In contrast, QE61 Disappearance or death of family member and its subcategories refer to the event itself.

QE6Y	Other specified problems associated with absence, loss or death of others
QE6Z	Problems associated with absence, loss or death of others, unspecified

Problems related to primary support group, including family circumstances

QE70	Problems related to primary support group, including family circumstances
QE70.0	Inadequate family support
QE70.1	Disruption of family by separation or divorce
QE70.2	Dependent relative needing care at home
QE70.Z	Problem related to primary support group, including family circumstance, unspecified

Problems associated with upbringing

QE90 Inadequate parental supervision or control

- Inadequate parental supervision or control refers to a lack of parental knowledge of what the child is doing or where the child is; poor control; lack of concern, understanding or comprehension or lack of attempted intervention when the child is in risky situations.

QE91 Parental overprotection

QE92 Altered pattern of family relationships in childhood

- Altered pattern of family relationships in childhood refers to the departure of a family member or arrival of a new person into a family, resulting in adverse change in child's relationships – may include new relationship or marriage by a parent, death or illness of a parent, illness or birth of a sibling.

QE93 Removal from home in childhood

QE94 Institutional upbringing

- Institutional upbringing refers to group foster care in which parenting responsibilities are largely taken over by some form of institution (such as residential nursery, orphanage or children's home), or therapeutic care over a prolonged period in which the child is in a hospital, convalescent home or the like, without at least one parent living with the child.

QE95 Inappropriate parental pressure or other abnormal qualities of upbringing

- Inappropriate parental pressure or other abnormal qualities of upbringing refers to parents forcing the child to be different from the local norm – either sex-inappropriate (e.g. dressing a boy in girl's clothes), age-inappropriate (e.g. forcing a child to take on responsibilities above their own age) or otherwise inappropriate (e.g. pressing the child to engage in unwanted or too difficult activities).

QE96 Events resulting in loss of self-esteem in childhood

- Events resulting in loss of self-esteem in childhood refers to events resulting in a negative self-reappraisal by the child, such as failure in tasks with high personal investment; disclosure or discovery of a shameful or stigmatizing personal or family event; or other humiliating experiences.

QE9Y Other specified problems associated with upbringing

QE9Z Problems associated with upbringing, unspecified

Problems associated with harmful or traumatic events

QE80 Personal experience of being a victim of crime or terrorism

QE81 Exposure to disaster, war or other hostilities

QE82 Personal history of maltreatment

See the section on relationship problems and maltreatment, p. 707

QE83 Personal frightening experience in childhood

QE84 Acute stress reaction

See the section on disorders specifically associated with stress, p. 361, for the full CDDR.

- Acute stress reaction refers to the development of transient emotional, somatic, cognitive or behavioural symptoms as a result of exposure to an event or situation (either short- or long-lasting) of an extremely threatening or horrific nature (e.g. natural or human-made disasters, combat, serious accidents, sexual violence, assault). Symptoms may include

autonomic signs of anxiety (e.g. tachycardia, sweating, flushing), being in a daze, confusion, sadness, anxiety, anger, despair, overactivity, inactivity, social withdrawal or stupor. The response to the stressor is considered to be normal given the severity of the stressor, and usually begins to subside within a few days after the event or following removal from the threatening situation.

QE9Y Other specified problems associated with harmful or traumatic events

QE9Z Problems associated with harmful or traumatic events, unspecified

Problems associated with social or cultural environment

QE00 Acculturation difficulty

- Acculturation difficulty refers to problems resulting from the inability to adjust to a different culture or environment.

QE02 Social role conflict

QE03 Social exclusion or rejection

- Social exclusion or rejection refers to exclusion and rejection on the basis of personal characteristics such as physical appearance, sexual orientation, gender identity and expression, illness or behaviour.

QE04 Personal experience of being a target of perceived adverse discrimination or persecution

- Target of perceived adverse discrimination or persecution refers to persecution or discrimination – real or perceived as reality by an individual – on the basis of membership in some group (such as defined by skin colour, religion, ethnic origin, sexual orientation, gender identity and expression) rather than personal characteristics.

QE0Y	Other specified problems associated with social or cultural environment
QE0Z	Problems associated with social or cultural environment, unspecified

Problems associated with employment or unemployment

QD80	Problems associated with unemployment
QD81	Problems associated with a change of job
QD82	Problems associated with threat of job loss
QD83	Problems with employment conditions
QD83.0	Problem associated with uncongenial work
QD83.1	Problem associated with stressful work schedule
QD83.Y	Other specified problem with employment conditions
QD84	Occupational exposure to risk factors
QD85	Burnout

- Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and a sense of ineffectiveness and lack of accomplishment. Burnout refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life.

QD8Y	Other specified problems associated with employment or unemployment
QD8Z	Problems associated with employment or unemployment, unspecified

Problems associated with education

QD90	Problems associated with illiteracy or low-level literacy
QD91	Problems associated with unavailable or unattainable education
QD92	Problems with educational progress
QD9Y	Other specified problems associated with education
QD9Z	Problems associated with education, unspecified

Other reasons for contact with mental health services

QE01	Stress, not elsewhere classified
QA1A	Discussion of issues surrounding impending death
QA1B	Concern about or fear of medical treatment
QA1C	Person with feared complaint in whom no diagnosis is made

QD3Z Concern about body appearance, unspecified

QE50.7 Personality difficulty

See the section on personality disorders and related traits, p. 553.

- Personality difficulty refers to pronounced personality characteristics that may affect treatment or health services but do not rise to the level of severity to merit a diagnosis of personality disorder. Personality difficulty is characterized by longstanding difficulties (e.g. at least 2 years) in the individual's way of experiencing and thinking about the self, others and the world. In contrast to personality disorder, these difficulties are manifested in cognitive and emotional experience and expression only intermittently (e.g. during times of stress) or at low intensity. The difficulties are associated with some problems in functioning, but these are insufficiently severe to cause notable disruption in social, occupational and interpersonal relationships, or may be limited to specific relationships or situations.

QC30 Malingering

- Malingering is the feigning, intentional production or significant exaggeration of physical or psychological symptoms, or intentional misattribution of genuine symptoms to an unrelated event or series of events when this is specifically motivated by external incentives or rewards such as escaping duty or work, mitigating punishment, obtaining medications or drugs, or receiving unmerited recompense such as disability compensation or personal injury damages award.

Problems associated with health behaviours

Hazardous substance use

See the section on disorders due to substance use, p. 441.

QE10 Hazardous alcohol use

- Hazardous alcohol use refers to a pattern of alcohol use that appreciably increases the risk of harmful physical or mental health consequences – to the user or to others – to an extent

that warrants attention and advice from health professionals. The increased risk may be from the frequency of alcohol use, from the amount used on a given occasion, from risky behaviours associated with alcohol use or the context of use, or from a combination of these. The risk may be related to short-term effects of alcohol or to longer-term cumulative effects on physical or mental health or functioning. Hazardous alcohol use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of alcohol use often persists in spite of awareness of increased risk of harm to the user or to others.

QE11 Hazardous drug use

- Hazardous drug use refers to a pattern of use of psychoactive substances other than nicotine or alcohol that appreciably increases the risk of harmful physical or mental health consequences – to the user or to others – to an extent that warrants attention and advice from health professionals. The increased risk may be from the frequency of substance use, from the amount used on a given occasion, from risky behaviours associated with substance use or the context of use, from a harmful route of administration, or from a combination of these. The risk may be related to short-term effects of the substance or to longer-term cumulative effects on physical or mental health or functioning. Hazardous drug use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of drug use often persists in spite of awareness of increased risk of harm to the user or to others.

Specify substance(s), if known:

QE11.0 Hazardous use of opioids
QE11.1 Hazardous use of cannabis
QE11.2 Hazardous use of sedatives, hypnotics or anxiolytics
QE11.3 Hazardous use of cocaine
QE11.4 Hazardous use of stimulants, including amfetamines, methamfetamine and methcathinone
QE11.5 Hazardous use of caffeine
QE11.6 Hazardous use of MDMA or related drugs
QE11.7 Hazardous use of dissociative drugs, including ketamine and PCP
QE11.8 Hazardous use of other specified psychoactive substance
QE11.9 Hazardous use of unknown or unspecified psychoactive substance
QE11.Y Other specified hazardous drug use
QE11.Z Hazardous drug use, unspecified

QE12 Hazardous nicotine use

- Hazardous nicotine use refers to a pattern of nicotine use that appreciably increases the risk of harmful physical or mental health consequences – to the user or to others – to an extent that warrants attention and advice from health professionals. Most often nicotine is consumed in the form of tobacco, but there are also other forms of nicotine delivery (e.g. nicotine vapour). Hazardous nicotine use has not yet reached the level of having caused harm to physical or mental health of the user or others around the user. The pattern of nicotine use often persists in spite of awareness of increased risk of harm to the user or to others. This category is not intended to include the use of nicotine replacement therapies under medical supervision when these are used as part of attempts to stop or reduce smoking.

QE1Y Other specified hazardous substance use

Hazardous gambling or gaming

See the section on disorders due to addictive behaviours, p. 506.

QE21 Hazardous gambling or betting

- Hazardous gambling or betting refers to a pattern of gambling or betting that appreciably increases the risk of harmful physical or mental health consequences to the individual or to others around this individual. The increased risk may be from the frequency of gambling or betting, from the amount of time spent on these activities or the context of gambling or betting, from the neglect of other activities and priorities, from risky behaviours associated with gambling or betting or its context, from the adverse consequences of gambling or betting, or from a combination of these. The pattern of gambling or betting often persists in spite of awareness of increased risk of harm to the individual or to others.

QE22 Hazardous gaming

- Hazardous gaming refers to a pattern of gaming, either online or offline that appreciably increases the risk of harmful physical or mental health consequences to the individual or to others around this individual. The increased risk may be from the frequency of gaming, from the amount of time spent on these activities, from the neglect of other activities and priorities, from risky behaviours associated with gaming or its context, from the adverse consequences of gaming, or from a combination of these. The pattern of gaming often persists in spite of awareness of increased risk of harm to the individual or to others.

Other problems associated with health behaviours

QE20	Lack of physical exercise
QE23	Problems with inappropriate diet or eating habits
QE24	Problems with hygiene behaviours
QE25	Problems with oral health behaviours
QE26	Problems with sun exposure behaviour
QE27	Problems with behaviours related to psychological health or well-being
QE28	Problems with health literacy
QE2Y	Problems with other specified health-related behaviours
QE2Z	Problems with health-related behaviours, unspecified

Contact with health services for counselling

QA10	Contact with health services for dietary counselling or surveillance
QA11	Contact with health services for alcohol use counselling or surveillance
QA12	Contact with health services for drug use counselling or surveillance
QA13	Contact with health services for tobacco use counselling

QA14 Contact with health services for human immunodeficiency virus counselling

- Human immunodeficiency virus counselling can be defined as accessible HIV counselling services that meet the needs of clients and providers in an equitable and acceptable manner, within the resources available and in line with national guidelines. Counselling should increase knowledge of HIV prevention and should help the client to focus on solutions to risk reduction.

QA15 Counselling related to sexuality

QA15.0 Counselling related to sexual attitudes

QA15.1 Counselling related to sexual behaviour and orientation or sexual relationships of the person

QA15.2 Counselling related to sexual behaviour and orientation or sexual relationships of the person of third party

QA15.3 Counselling related to combined sexual attitudes, sexual behaviour and sexual relationships

QA15.Y Other specified counselling related to sexuality

QA15.Z Counselling related to sexuality, unspecified

QA16 Individual psychological or behavioural counselling

QA17 Marital or couples counselling

QA18 Family counselling

QA19 Group counselling

QA1Y Contact with health services for other specified counselling

QA1Z Contact with health services for unspecified counselling

Contact with health services for reasons associated with reproduction[8]

QA20	Contact with health services for concerns about pregnancy
QA21	Contact with health services for contraceptive management
QA30	Contact with health services for medically assisted reproduction

Problems associated with social insurance or welfare

QE30	Insufficient social insurance support
QE30.0	Insufficient social insurance support, aged
QE30.1	Insufficient social insurance support, disability
QE30.2	Insufficient social insurance support, unemployment
QE30.4	Insufficient social insurance support, family support
QE31	Insufficient social welfare support
QE31.0	Insufficient social welfare support, child protection
QE31.1	Insufficient social welfare support, protection against domestic violence
QE31.2	Insufficient social welfare support, protection against homelessness
QE31.3	Insufficient social welfare support, post prison services

8 A detailed listing of categories in this section can be found at ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS) [website]. Geneva: World Health Organization; 2023 (https://ICD.who.int/browse11/l-m/en#/).

QE3Y	Other specified problems associated with social insurance or welfare
QE3Z	Problems associated with social insurance or welfare, unspecified

Problems associated with the justice system

QE40	Problems associated with conviction in civil or criminal proceedings without imprisonment
QE41	Problems associated with imprisonment and other incarceration
QE42	Problems associated with release from prison
QE4Y	Other specified problems associated with the justice system
QE4Z	Problems associated with the justice system, unspecified

Problems associated with finances

QD50	Poverty
QD51	Low income
QD5Y	Other specified problems associated with finances
QD5Z	Problems associated with finances, unspecified

Problems associated with inadequate drinking-water or nutrition

QD60	Problems associated with inadequate drinking-water
QD61	Inadequate food
QD6Z	Problems associated with drinking-water or nutrition, unspecified

Problems associated with the environment

QD70	Problems associated with the natural environment or human-made changes to the environment

QD70.0	Problem associated with exposure to noise
QD70.1	Problem associated with exposure to air pollution
QD70.2	Problem associated with exposure to water pollution
QD70.3	Problem associated with exposure to soil pollution
QD70.4	Problem associated with exposure to exposure to radiation
QD70.5	Problem associated with exposure to exposure to tobacco smoke

Note: this refers to second-hand smoke, and not to tobacco use by the individual.

QD70.6	Problem associated with inadequate access to electricity
QD70.Z	Problem associated with the natural environment or human-made changes to the environment, unspecified

QD71	Problems associated with housing
QD71.0	Homelessness
QD71.1	Inadequate housing
QD71.2	Problem related to living in a residential institution
QD71.Z	Problem associated with housing, unspecified
QD7Y	Other specified problems associated with the environment
QD7Z	Problems associated with the environment, unspecified

Crosswalk from ICD-11 mental, behavioural and neurodevelopmental disorders to ICD-10 for clinician use

This table provides a crosswalk or mapping specifically designed for use by clinicians from categories in this ICD-11 chapter on mental, behavioural and neurodevelopmental disorders to the nearest equivalent ICD-10 category. This will be useful, for example, in settings where there has been a shift to use of ICD-11 for clinical purposes, but where data or health reporting systems are still in transition and require the use of ICD-10 codes.

Use of this table assumes that the clinician has already made their diagnosis according to the ICD-11 CDDR. This table is not valid for mapping categories from the ICD-10 mental and behavioural disorders to ICD-11 because it does not reflect the full content of the ICD-10 mental and behavioural disorders.

This crosswalk is not intended for use in health statistics or in the coding of medical records because, in a substantial number of instances, selecting among multiple possible ICD-10 categories depends on clinical information that will not be available in those contexts. Additional information to assist clinicians in making these distinctions is provided in the "Notes" column on the right.

In the table that follows, the ICD-11 categories are listed in the left column in the order in which they appear in the classification. The closest available ICD-10 category to represent that ICD-11 disorder (i.e. the preferred code) is provided as the first entry in the middle column. Many of these are 4-character ICD-10 codes (e.g. F80.1), but in other instances a 3-character code (e.g. F20) or a 5-character code (e.g. F10.24) best captures the ICD-11 category. Where ICD-10 5-character codes appear, these are taken from *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines*, which in some cases include more detailed coding options than the statistical version of ICD-10.

Data systems and/or reporting requirements in some health systems and countries may require that 4-character ICD-10 codes are used if they are available, so that a 3-character code is not accepted if a 4-character subcategory exists. Similarly, many data systems do not accept 5-character ICD-10 codes, allowing a maximum of 4 characters. In situations in which the nearest equivalent ICD-10 category is not a 4-character code, a 4-character coding option is also provided.

Additional coding or reporting requirements vary widely across settings and countries. The mappings provided here may therefore require adjustment based on the requirements of the specific clinical setting. This crosswalk is not intended to contravene any guidance that may be provided by the relevant health system or government.

In a couple of specific instances (e.g. ICD-11 Body dysmorphic disorder), coding information provided in *The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines* is not consistent with current evidence. The mappings provided in the table are consistent with the ICD-11 conceptualizations in these cases, with such deviations described in the "Notes" column.

ICD-11	ICD-10	Notes
Neurodevelopmental disorders		
6A00 Disorders of intellectual development		
6A00.0 Disorder of intellectual development, mild	F70 Mild mental retardation 4-character code: F70.9 Mild mental retardation without mention of impairment of behaviour	
6A00.1 Disorder of intellectual development, moderate	F71 Moderate mental retardation 4-character code: F71.9 Moderate mental retardation without mention of impairment of behaviour	
6A00.2 Disorder of intellectual development, severe	F72 Severe mental retardation 4-character code: F72.9 Severe mental retardation without mention of impairment of behaviour	
6A00.3 Disorder of intellectual development, profound	F73 Profound mental retardation 4-character code: F73.9 Profound mental retardation without mention of impairment of behaviour	
6A00.4 Disorder of intellectual development, provisional	F78 Other mental retardation 4-character code: F78.9 Other mental retardation without mention of impairment of behaviour	
6A00.Z Disorder of intellectual development, unspecified	F79 Unspecified mental retardation 4-character code: F79.9 Unspecified mental retardation without mention of impairment of behaviour	
6A01 Developmental speech and language disorders	F80 Specific developmental disorders of speech and language	
6A01.0 Developmental speech sound disorder	F80.0 Specific speech articulation disorder	
6A01.1 Developmental speech fluency disorder	F98.5 Stuttering [stammering] AND/OR F98.6 Cluttering	Select the appropriate category based on clinical presentation. There is no diagnostic distinction in ICD-11 between the forms of speech dysfluency described in ICD-10 as stuttering and cluttering.

ICD-11	ICD-10	Notes
6A01.2 Developmental language disorder	See below	For clinical purposes, the type of language impairment (e.g. receptive, expressive, other) should be specified. If no information is available about the type of language impairment, F80.9 Developmental disorder of speech or language, unspecified, can be used.
6A01.20 Developmental language disorder with impairment of receptive and expressive language	F80.1 Expressive language disorder AND F80.2 Receptive language disorder	
6A01.21 Developmental language disorder with impairment of mainly expressive language	F80.1 Expressive language disorder	
6A01.22 Developmental language disorder with impairment of mainly pragmatic language	F80.8 Other developmental disorders of speech and language	
6A01.23 Developmental language disorder with other specified language impairment	F80.8 Other developmental disorders of speech and language	
6A01.Y Other specified developmental speech or language disorder	F80.8 Other developmental disorders of speech and language	
6A01.Z Developmental speech or language disorder, unspecified	F80.9 Developmental disorder of speech and language, unspecified	
6A02 Autism spectrum disorder	F84.0 Childhood autism OR F84.1 Atypical autism OR F84.5 Asperger syndrome	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later). Regardless of onset, use F84.5 if there is no general impairment in intellectual functioning or functional language.
6A02.0 Autism spectrum disorder without disorder of intellectual development and with mild or no impairment of functional language	F84.5 Asperger syndrome	
6A02.1 Autism spectrum disorder with disorder of intellectual development and with mild or no impairment of functional language	F84.0 Childhood autism OR F84.1 Atypical autism	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later).
6A02.2 Autism spectrum disorder without disorder of intellectual development and with impaired functional language	F84.0 Childhood autism OR F84.1 Atypical autism	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later).
6A02.3 Autism spectrum disorder with disorder of intellectual development and with impaired functional language	F84.0 Childhood autism OR F84.1 Atypical autism	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later).

ICD-11	ICD-10	Notes
6A02.5 Autism spectrum disorder with disorder of intellectual development and with complete, or almost complete, absence of functional language	F84.0 Childhood autism OR F84.1 Atypical autism	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later).
6A02.Y Other specified autism spectrum disorder	F84.0 Childhood autism OR F84.1 Atypical autism OR F84.5 Asperger syndrome	Use F84.1 if it is unclear that onset was prior to the age of 3 years (keeping in mind that people may come to clinical attention much later). Regardless of onset, use F84.5 if there is no general impairment in intellectual functioning or functional language.
6A02.Z Autism spectrum disorder, unspecified	F84.9 Pervasive developmental disorder, unspecified	
6A03 Developmental learning disorder	F81 Specific developmental disorders of scholastic skills	
6A03.0 Developmental learning disorder with impairment in reading	F81.0 Specific reading disorder	
6A03.1 Developmental learning disorder with impairment in written expression	F81.1 Specific spelling disorder AND/OR F81.8 Other developmental disorders of scholastic skills	ICD-11 6A03.1 also includes expressive writing impairment. If the impairment is in an area other than spelling, then F81.8 Other developmental disorders of scholastic skills may be used instead. Both ICD-10 diagnoses may be assigned if appropriate.
6A03.2 Developmental learning disorder with impairment in mathematics	F81.2 Specific disorder of arithmetical skills	
6A03.3 Developmental learning disorder with other specified impairment of learning	F81.8 Other developmental disorders of scholastic skills	
6A03.Z Developmental learning disorder, unspecified	F81.9 Developmental disorder of scholastic skills, unspecified	
6A04 Developmental motor coordination disorder	F82 Specific developmental disorder or motor function	
6A05 Attention deficit hyperactivity disorder	F90 Hyperkinetic disorders OR F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Use F98.8 if there are no hyperactive-impulsive symptoms.
6A05.0 Attention deficit hyperactivity disorder with predominantly inattentive presentation	F90 Hyperkinetic disorders OR F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Use F98.8 if there are no hyperactive-impulsive symptoms.
6A05.1 Attention deficit hyperactivity disorder with predominantly hyperactive-impulsive presentation	F90.8 Other hyperkinetic disorder	
6A05.2 Attention deficit hyperactivity disorder with combined presentation	F90.0 Hyperkinetic disorder with disturbance of activity and attention	

ICD-11	ICD-10	Notes
6A05.Y Attention deficit hyperactivity disorder with other specified presentation	F90.8 Other hyperkinetic disorders OR F98.8 Other specified behavioural and emotional disorders with onset usually occurring in childhood and adolescence	Use F98.8 if there are no hyperactive-impulsive symptoms.
6A05.Z Attention deficit hyperactivity disorder, presentation unspecified	F98.9 Unspecified behavioural and emotional disorders with onset usually occurring in childhood and adolescence	
6A06 Stereotyped movement disorder	F98.4 Stereotyped movement disorders	
6A06.0 Stereotyped movement disorder without self-injury	F98.4 Stereotyped movement disorders	
6A06.1 Stereotyped movement disorder with self-injury	F98.4 Stereotyped movement disorders	
6A06.Z Stereotyped movement disorder, unspecified	F98.4 Stereotyped movement disorders	
8A05.0 Primary tics and tic disorders	F95 Tic disorders	
8A05.00 Tourette syndrome	F95.2 Combined vocal and multiple motor tic disorder [de la Tourette]	
8A05.01 Chronic motor tic disorder	F95.1 Chronic motor or vocal tic disorder	
8A05.02 Chronic phonic tic disorder	F95.1 Chronic motor or vocal tic disorder	
8A05.0Y Other specified primary tics and tic disorder	F95.8 Other tic disorders	
8A05.0Z Primary tics and tic disorder, unspecified	F95.9 Tic disorder, unspecified	
6A0Y Other specified neurodevelopmental disorder	F88 Other disorders of psychological development No 4-character code available	
6A0Z Neurodevelopmental disorder, unspecified	F89 Unspecified disorder of psychological development No 4-character code available	
Schizophrenia and other primary psychotic disorders		
6A20 Schizophrenia	F20 Schizophrenia 4-character code: F20.9 Schizophrenia, unspecified	
6A20.0 Schizophrenia, first episode (including all subcategories 6A20.00–6A20.0Z)	F20 Schizophrenia 4-character code: F20.8 Other schizophrenia	
6A20.1 Schizophrenia, multiple episodes (including all subcategories 6A20.10–6A20.1Z)	F20 Schizophrenia 4-character code: F20.8 Other schizophrenia	

ICD-11	ICD-10	Notes
6A20.2 Schizophrenia, continuous (including all subcategories 6A20.20–6A20.2Z)	F20 Schizophrenia 4-character code: F20.8 Other schizophrenia	
6A20.Y Other specified episode of schizophrenia	F20 Schizophrenia 4-character code: F20.8 Other schizophrenia	
6A20.Z Schizophrenia, episode unspecified	F20 Schizophrenia 4-character code: F20.8 Other schizophrenia	
6A21 Schizoaffective disorder	F25 Schizoaffective disorders 4-character code: F25.9 Schizoaffective disorder, unspecified	
6A21.0 Schizoaffective disorder, first episode (including all subcategories 6A21.00–6A21.0Z)	F25 Schizoaffective disorders 4-character code: F25.8 Other schizoaffective disorders	
6A21.1 Schizoaffective disorder, multiple episodes (including all subcategories 6A21.10–6A21.1Z)	F25 Schizoaffective disorders 4-character code: F25.8 Other schizoaffective disorders	
6A21.2 Schizoaffective disorder, continuous (including all subcategories 6A21.20–6A21.2Z)	F25 Schizoaffective disorders 4-character code: F25.8 Other schizoaffective disorders	
6A21.Y Other specified schizoaffective disorder	F25 Schizoaffective disorders 4-character code: F25.8 Other schizoaffective disorders	
6A21.Z Schizoaffective disorder, unspecified	F25 Schizoaffective disorders 4-character code: F25.8 Other schizoaffective disorders	
6A22 Schizotypal disorder	F21 Schizotypal disorder No 4-character code available	
6A23 Acute and transient psychotic disorder	F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia	
6A23.0 Acute and transient psychotic disorder, first episode (including all subcategories 6A23.00–6A23.0Z)	F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia	
6A23.1 Acute and transient psychotic disorder, multiple episodes (including all subcategories 6A23.10–6A23.1Z)	F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia	
6A23.Y Other specified acute and transient psychotic disorder	F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia	

ICD-11	ICD-10	Notes
6A23.Z Acute and transient psychotic disorder, unspecified	F23.0 Acute polymorphic psychotic disorder without symptoms of schizophrenia	
6A24 Delusional disorder	F22.0 Delusional disorder	
6A24.0 Delusional disorder, currently symptomatic	F22.0 Delusional disorder	
6A24.1 Delusional disorder, in partial remission	F22.0 Delusional disorder	
6A24.2 Delusional disorder, in full remission	F22.0 Delusional disorder	
6A24.Z Delusional disorder, unspecified	F22.0 Delusional disorder	
6A2Y Other specified primary psychotic disorder	F28 Other nonorganic psychotic disorders No 4-character code available	
6A2Z Schizophrenia or other primary psychotic disorder, unspecified	F29 Unspecified nonorganic psychosis No 4-character code available	
Catatonia		
6A40 Catatonia associated with another mental disorder	F20.2 Catatonic schizophrenia OR F99 Mental disorder, not otherwise specified	F20.2 should only be used when the associated mental disorder is schizophrenia.
6A41 Catatonia induced by substances or medications	F19.8 Other mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6A4Z Catatonia, unspecified	F99 Mental disorder, not otherwise specified	
Mood disorders		
Bipolar and related disorders		
6A60 Bipolar type I disorder	F31 Bipolar affective disorder 4-character code: F31.9 Bipolar affective disorder, unspecified	
6A60.0 Bipolar type I disorder, current episode manic, without psychotic symptoms	F31.1 Bipolar affective disorder, current episode manic without psychotic symptoms	
6A60.1 Bipolar type I disorder, current episode manic, with psychotic symptoms	F31.2 Bipolar affective disorder, current episode manic with psychotic symptoms	
6A60.2 Bipolar type I disorder, current episode hypomanic	F31.0 Bipolar affective disorder, current episode hypomanic	
6A60.3 Bipolar type I disorder, current episode depressive, mild	F31.3 Bipolar affective disorder, current episode mild or moderate depression	
6A60.4 Bipolar type I disorder, current episode depressive, moderate without psychotic symptoms	F31.3 Bipolar affective disorder, current episode mild or moderate depression	
6A60.5 Bipolar type I disorder, current episode depressive, moderate with psychotic symptoms	F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms	In ICD-10, the presence of psychotic symptoms in the context of a depressive episode means that the episode is automatically rated as severe.

ICD-11	ICD-10	Notes
6A60.6 Bipolar type I disorder, current episode depressive, severe without psychotic symptoms	F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms	
6A60.7 Bipolar type I disorder, current episode depressive, severe with psychotic symptoms	F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms	
6A60.8 Bipolar type I disorder, current episode depressive, unspecified severity	F31.9 Bipolar affective disorder, unspecified	
6A60.9 Bipolar type I disorder, current episode mixed, without psychotic symptoms	F31.6 Bipolar affective disorder, current episode mixed	
6A60.A Bipolar type I disorder, current episode mixed, with psychotic symptoms	F31.6 Bipolar affective disorder, current episode mixed	
6A60.B Bipolar type I disorder, currently in partial remission, most recent episode manic or hypomanic	F31.8 Other bipolar affective disorders	
6A60.C Bipolar type I disorder, currently in partial remission, most recent episode depressive	F31.8 Other bipolar affective disorders	
6A60.D Bipolar type I disorder, currently in partial remission, most recent episode mixed	F31.8 Other bipolar affective disorders	
6A60.E Bipolar type I disorder, currently in partial remission, most recent episode unspecified	F31.8 Other bipolar affective disorders	
6A60.F Bipolar type I disorder, currently in full remission	F31.7 Bipolar affective disorder, currently in remission	
6A60.Y Other specified bipolar type I disorder	F31.8 Other bipolar affective disorders	
6A60.Z Bipolar type I disorder, unspecified	F31.9 Bipolar affective disorder, unspecified	
6A61 Bipolar type II disorder	F31 Bipolar affective disorder	
6A61.0 Bipolar type II disorder, current episode hypomanic	F31.0 Bipolar affective disorder, current episode hypomanic	
6A61.1 Bipolar type II disorder, current episode depressive, mild	F31.3 Bipolar affective disorder, current episode mild or moderate depression	
6A61.2 Bipolar type II disorder, current episode depressive, moderate without psychotic symptoms	F31.3 Bipolar affective disorder, current episode mild or moderate depression	
6A61.3 Bipolar type II disorder, current episode depressive, moderate with psychotic symptoms	F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms	In ICD-10, the presence of psychotic symptoms in the context of a depressive episode means that the episode is automatically rated as severe.
6A61.4 Bipolar type II disorder, current episode depressive, severe without psychotic symptoms	F31.4 Bipolar affective disorder, current episode severe depression without psychotic symptoms	
6A61.5 Bipolar type II disorder, current episode depressive, severe with psychotic symptoms	F31.5 Bipolar affective disorder, current episode severe depression with psychotic symptoms	
6A61.6 Bipolar type II disorder, current episode depressive, unspecified severity	F31.9 Bipolar affective disorder, unspecified	
6A61.7 Bipolar type II disorder, currently in partial remission, most recent episode hypomanic	F31.8 Other bipolar affective disorders	
6A61.8 Bipolar type II disorder, currently in partial remission, most recent episode depressive	F31.8 Other bipolar affective disorders	
6A61.9 Bipolar type II disorder, currently in partial remission, most recent episode unspecified	F31.8 Other bipolar affective disorders	
6A61.A Bipolar type II disorder, currently in full remission	F31.7 Bipolar affective disorder, currently in remission	
6A61.Y Other specified bipolar type II disorder	F31.8 Other bipolar affective disorders	

ICD-11	ICD-10	Notes
6A61.Z Bipolar type II disorder, unspecified	F31.9 Bipolar affective disorder, unspecified	
6A62 Cyclothymic disorder	F34.0 Cyclothymia	
6A6Y Other specified bipolar or related disorder	F31.8 Other bipolar affective disorders	
6A6Z Bipolar or related disorder, unspecified	F31.9 Bipolar affective disorder, unspecified	
Depressive disorders		
6A70 Single episode depressive disorder	F32 Depressive episode 4-character code: F32.9 Depressive episode, unspecified	
6A70.0 Single episode depressive disorder, mild	F32.0 Mild depressive episode	
6A70.1 Single episode depressive disorder, moderate, without psychotic symptoms	F32.1 Moderate depressive episode	
6A70.2 Single episode depressive disorder, moderate, with psychotic symptoms	F32.3 Severe depressive episode with psychotic symptoms	In ICD-10, the presence of psychotic symptoms in the context of a depressive episode means that the episode is automatically rated as severe.
6A70.3 Single episode depressive disorder, severe, without psychotic symptoms	F32.2 Severe depressive episode without psychotic symptoms	
6A70.4 Single episode depressive disorder, severe, with psychotic symptoms	F32.3 Severe depressive episode with psychotic symptoms	
6A70.5 Single episode depressive disorder, unspecified severity	F32.9 Depressive episode, unspecified	
6A70.6 Single episode depressive disorder, currently in partial remission	F32.8 Other depressive episodes	
6A70.7 Single episode depressive disorder, currently in full remission	No diagnosis	In ICD-10, remission can only apply to recurrent depressive disorder. If an ICD-10 code must be provided, the most appropriate option would be F32.9 Depressive episode, unspecified.
6A70.Y Other specified single episode depressive disorder	F32.8 Other depressive episodes	
6A70.Z Single episode depressive disorder, unspecified	F32.9 Depressive episode, unspecified	
6A71 Recurrent depressive disorder	F33.0 Recurrent depressive disorder OR F33.9 Recurrent depressive disorder, unspecified	
6A71.0 Recurrent depressive disorder, current episode mild	F33.0 Recurrent depressive disorder, current episode mild	
6A71.1 Recurrent depressive disorder, current episode moderate, without psychotic symptoms	F33.1 Recurrent depressive disorder, current episode moderate	

ICD-11	ICD-10	Notes
6A71.2 Recurrent depressive disorder, current episode moderate, with psychotic symptoms	F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms	In ICD-10, the presence of psychotic symptoms in the context of a depressive episode means that the episode is automatically rated as severe.
6A71.3 Recurrent depressive disorder, current episode severe, without psychotic symptoms	F33.2 Recurrent depressive disorder, current episode severe without psychotic symptoms	
6A71.4 Recurrent depressive disorder, current episode severe, with psychotic symptoms	F33.3 Recurrent depressive disorder, current episode severe with psychotic symptoms	
6A71.5 Recurrent depressive disorder, current episode, unspecified severity	F33.9 Recurrent depressive disorder, unspecified	
6A71.6 Recurrent depressive disorder, currently in partial remission	F33.8 Other recurrent depressive disorders	
6A71.7 Recurrent depressive disorder, currently in full remission	F33.4 Recurrent depressive disorder, currently in remission	
6A71.Y Other specified recurrent depressive disorder	F33.8 Other recurrent depressive disorders	
6A71.Z Recurrent depressive disorder, unspecified	F33.9 Recurrent depressive disorder, unspecified	
6A72 Dysthymic disorder	F34.1 Dysthymia	
6A73 Mixed depressive and anxiety disorder	F41.2 Mixed anxiety and depressive disorder	
6A7Y Other specified depressive disorder	F38.8 Other specified mood [affective] disorder	
6A7Z Depressive disorder, unspecified	F39 Unspecified mood [affective] disorder No 4-character code available	
6A8Y Other specified mood disorder	F38.8 Other specified mood [affective] disorder	
6A8Z Mood disorder, unspecified	F39 Unspecified mood [affective] disorder No 4-character code available	
Anxiety and fear-related disorders		
6B00 Generalized anxiety disorder	F41.1 Generalized anxiety disorder	
6B01 Panic disorder	F41.0 Panic disorder [episodic paroxysmal anxiety]	
6B02 Agoraphobia	F40.0 Agoraphobia	
6B03 Specific phobia	F40.2 Specific (isolated) phobias OR F93.1 Phobic anxiety disorder of childhood	Use F93.1 if the individual is less than 18 years of age.
6B04 Social anxiety disorder	F40.1 Social phobias OR F93.2 Social anxiety disorder of childhood	Use F93.2 if the individual is less than 6 years of age.
6B05 Separation anxiety disorder	F41.8 Other specified anxiety disorders OR F93.0 Separation anxiety disorder of childhood	Use F93.0 if the individual is less than 6 years of age.
6B06 Selective mutism	F94.0 Elective mutism	

ICD-11	ICD-10	Notes
6B0Y Other specified anxiety or fear-related disorder	F40.8 Other phobic anxiety disorders OR F41.8 Other specified anxiety disorders	Use F40.8 if there is a specific external stimulus or situation that triggers the anxiety symptoms; otherwise, use 41.8.
6B0Z Anxiety or fear-related disorder, unspecified	F40.9 Phobic anxiety disorder, unspecified OR F41.9 Anxiety disorder, unspecified	Use F40.9 if there is a specific external stimulus or situation that triggers the anxiety symptoms; otherwise, use 41.9.
Obsessive-compulsive and related disorders		
6B20 Obsessive-compulsive disorder	F42 Obsessive-compulsive disorder 4-character code: F42.9 Obsessive-compulsive disorder, unspecified	
6B20.0 Obsessive-compulsive disorder with fair to good insight	F42 Obsessive-compulsive disorder 4-character code: F42.9 Obsessive-compulsive disorder, unspecified	
6B20.1 Obsessive-compulsive disorder with poor to absent insight	F42 Obsessive-compulsive disorder 4-character code: F42.9 Obsessive-compulsive disorder, unspecified	
6B20.Z Obsessive-compulsive disorder, unspecified	F42.9 Obsessive-compulsive disorder, unspecified	
6B21 Body dysmorphic disorder	F42.8 Other obsessive-compulsive disorders	Mapping to F45.2 Hypochondriacal disorder is inconsistent with the ICD-11 conceptualization of body dysmorphic disorder.
6B21.0 Body dysmorphic disorder with fair to good insight	F42.8 Other obsessive-compulsive disorders	
6B21.1 Body dysmorphic disorder with poor to absent insight	F42.8 Other obsessive-compulsive disorders	Mapping to F22.8 Other persistent delusional disorders is inconsistent with the ICD-11 conceptualization of body dysmorphic disorder.
6B21.Z Body dysmorphic disorder, unspecified	F42.8 Other obsessive-compulsive disorders	
6B22 Olfactory reference disorder	F42.8 Other obsessive-compulsive disorders	
6B22.0 Olfactory reference disorder with fair to good insight	F42.8 Other obsessive-compulsive disorders	
6B22.1 Olfactory reference disorder with poor to absent insight	F42.8 Other obsessive-compulsive disorders	
6B22.Z Olfactory reference disorder, unspecified	F42.8 Other obsessive-compulsive disorders	
6B23 Hypochondriasis	F45.2 Hypochondriacal disorder	
6B23.0 Hypochondriasis with fair to good insight	F45.2 Hypochondriacal disorder	

ICD-11	ICD-10	Notes
6B23.1 Hypochondriasis with poor to absent insight	F45.2 Hypochondriacal disorder	
6B23.Z Hypochondriasis, unspecified	F45.2 Hypochondriacal disorder	
6B24 Hoarding disorder	F42.8 Other obsessive-compulsive disorders	
6B24.0 Hoarding disorder with fair to good insight	F42.8 Other obsessive-compulsive disorders	
6B24.1 Hoarding disorder with poor to absent insight	F42.8 Other obsessive-compulsive disorders	
6B24.Z Hoarding disorder, unspecified	F42.8 Other obsessive-compulsive disorders	
6B25 Body-focused repetitive behaviour disorders	F63.8 Other habit and impulse disorders	
6B25.0 Trichotillomania (hair-pulling disorder)	F63.3 Trichotillomania	
6B25.1 Excoriation (skin-picking) disorder	F63.8 Other habit and impulse disorders	
6B25.Y Other specified body-focused repetitive behaviour disorder	F63.8 Other habit and impulse disorders	
6B25.Z Body-focused repetitive behaviour disorder, unspecified	F63.9 Habit and impulse disorder, unspecified	
6B2Y Other specified obsessive-compulsive or related disorder	F42.8 Other obsessive-compulsive disorders	
6B2Z Obsessive-compulsive or related disorder, unspecified	F42.9 Obsessive-compulsive disorder, unspecified	
Disorders specifically associated with stress		
6B40 Post-traumatic stress disorder	F43.1 Post-traumatic stress disorder	
6B41 Complex post-traumatic stress disorder	F43.1 Post-traumatic stress disorder AND F62.0 Enduring personality change after catastrophic experience	
6B42 Prolonged grief disorder	F43.8 Other reactions to severe stress	Mapping to F43.2 Adjustment disorders is inconsistent with the ICD-11 conceptualization of prolonged grief disorder.
6B43 Adjustment disorder	F43.2 Adjustment disorders	
6B44 Reactive attachment disorder	F94.1 Reactive attachment disorder of childhood	
6B45 Disinhibited social engagement disorder	F94.2 Disinhibited attachment disorder of childhood	
6B4Y Other specified disorder specifically associated with stress	F43.8 Other reactions to severe stress	
6B4Z Disorder specifically associated with stress, unspecified	F43.9 Reaction to severe stress, unspecified	
QE84 Acute stress reaction	F43.0 Acute stress reaction	
Dissociative disorders		
6B60 Dissociative neurological symptom disorder	F44.9 Dissociative [conversion] disorder, unspecified	
6B60.0 Dissociative neurological symptom disorder with visual disturbance	F44.6 Dissociative anaesthesia and sensory loss	
6B60.1 Dissociative neurological symptom disorder with auditory disturbance	F44.6 Dissociative anaesthesia and sensory loss	
6B60.2 Dissociative neurological symptom disorder with vertigo or dizziness	F44.6 Dissociative anaesthesia and sensory loss	

ICD-11	ICD-10	Notes
6B60.3 Dissociative neurological symptom disorder with other sensory disturbance	F44.6 Dissociative anaesthesia and sensory loss	
6B60.4 Dissociative neurological symptom disorder with non-epileptic seizures	F44.5 Dissociative convulsions	
6B60.5 Dissociative neurological symptom disorder with speech disturbance	F44.4 Dissociative motor disorders	
6B60.6 Dissociative neurological symptom disorder with paresis or weakness	F44.4 Dissociative motor disorders	
6B60.7 Dissociative neurological symptom disorder with gait disturbance	F44.4 Dissociative motor disorders	
6B60.8 Dissociative neurological symptom disorder with movement disturbance	F44.4 Dissociative motor disorders	
6B60.80 Dissociative neurological symptom disorder with chorea	F44.4 Dissociative motor disorders	
6B60.81 Dissociative neurological symptom disorder with myoclonus	F44.4 Dissociative motor disorders	
6B60.82 Dissociative neurological symptom disorder with tremor	F44.4 Dissociative motor disorders	
6B60.83 Dissociative neurological symptom disorder with dystonia	F44.4 Dissociative motor disorders	
6B60.84 Dissociative neurological symptom disorder with facial spasm	F44.4 Dissociative motor disorders	
6B60.85 Dissociative neurological symptom disorder with parkinsonism	F44.4 Dissociative motor disorders	
6B60.8Y Dissociative neurological symptom disorder with other specified movement disturbance	F44.4 Dissociative motor disorders	
6B60.8Z Dissociative neurological symptom disorder with unspecified movement disturbance	F44.4 Dissociative motor disorders	
6B60.9 Dissociative neurological symptom disorder with cognitive symptoms	F44.8 Other dissociative [conversion] disorders	
6B60.Y Dissociative neurological symptom disorder with other specified symptoms	F44.8 Other dissociative [conversion] disorders	
6B60.Z Dissociative neurological symptom disorder with unspecified symptoms	F44.9 Dissociative [conversion] disorder, unspecified	
6B61 Dissociative amnesia	F44.0 Dissociative amnesia	
6B61.0 Dissociative amnesia with dissociative fugue	F44.1 Dissociative fugue	
6B61.1 Dissociative amnesia without dissociative fugue	F44.0 Dissociative amnesia	
6B61.Z Dissociative amnesia, unspecified	F44.0 Dissociative amnesia	
6B62 Trance disorder	F44.3 Trance and possession disorders	
6B63 Possession trance disorder	F44.3 Trance and possession disorders	
6B64 Dissociative identity disorder	F44.81 Multiple personality disorder 4-character code: F44.8 Other dissociative [conversion] disorder	
6B65 Partial dissociative identity disorder	F44.8 Other dissociative [conversion] disorder	
6B66 Depersonalization-derealization disorder	F48.1 Depersonalization-derealization syndrome	
6B6Y Other specified dissociative disorder	F44.8 Other dissociative [conversion] disorders	
6B6Z Dissociative disorder, unspecified	F44.9 Dissociative [conversion] disorder, unspecified	

ICD-11	ICD-10	Notes
Feeding and eating disorders		
6B80 Anorexia nervosa	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	For ICD-10 F50.0, diagnostic requirements include BMI of less than 17.5, plus: amenorrhoea in women; loss of sexual interest and erectile dysfunction in men; or delayed puberty in adolescents. Otherwise, use F50.1.
6B80.0 Anorexia nervosa with significantly low body weight	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	See 6B80.
6B80.00 Anorexia nervosa with significantly low body weight, restricting pattern	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	See 6B80.
6B80.01 Anorexia nervosa with significantly low body weight, binge-purge pattern	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	See 6B80.
6B80.0Z Anorexia nervosa with significantly low body weight, unspecified	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	See 6B80.
6B80.1 Anorexia nervosa with dangerously low body weight	F50.0 Anorexia nervosa	
6B80.10 Anorexia nervosa with dangerously low body weight, restricting pattern	F50.0 Anorexia nervosa	
6B80.11 Anorexia nervosa with dangerously low body weight, binge-pure pattern	F50.0 Anorexia nervosa	
6B80.1Z Anorexia nervosa with dangerously low body weight, unspecified	F50.0 Anorexia nervosa	
6B80.2 Anorexia nervosa in recovery with normal body weight	F50.1 Atypical anorexia nervosa	
6B80.Y Other specified anorexia nervosa	F50.1 Atypical anorexia nervosa	
6B80.Z Anorexia nervosa, unspecified	F50.0 Anorexia nervosa OR F50.1 Atypical anorexia nervosa	For ICD-10 F50.0, diagnostic requirements include BMI of less than 17.5, plus: amenorrhoea in women; loss of sexual interest and erectile dysfunction in men; or delayed puberty in adolescents. Otherwise, use F50.1.
6B81 Bulimia nervosa	F50.2 Bulimia nervosa	
6B82 Binge-eating disorder	F50.8 Other eating disorders	
6B83 Avoidant-restrictive food intake disorder	F98.2 Feeding disorder of infancy or childhood OR F50.8 Other eating disorders	Use F98.2 if the individual is less than 12 years of age; otherwise, use F50.8.

ICD-11	ICD-10	Notes
6B84 Pica	F98.3 Pica of infancy and childhood OR F50.8 Other eating disorders	Use F98.3 if the individual is less than 12 years of age; otherwise, use F50.8.
6B85 Rumination-regurgitation disorder	F98.2 Feeding disorder of infancy and childhood OR F50.8 Other eating disorders	Use F98.2 if the individual is less than 12 years of age; otherwise, use F50.8.
6B8Y Other specified feeding or eating disorder	F50.8 Other eating disorders	
6B8Z Feeding or eating disorder, unspecified	F50.9 Eating disorder, unspecified	
Elimination disorders		
6C00 Enuresis	F98.0 Nonorganic enuresis	
6C00.0 Nocturnal enuresis	F98.0 Nonorganic enuresis	
6C00.1 Diurnal enuresis	F98.0 Nonorganic enuresis	
6C00.2 Nocturnal and diurnal enuresis	F98.0 Nonorganic enuresis	
6C00.Z Enuresis, unspecified	F98.0 Nonorganic enuresis	
6C01 Encopresis	F98.1 Nonorganic encopresis	
6C01.0 Encopresis with constipation or overflow incontinence	F98.1 Nonorganic encopresis	
6C01.1 Encopresis without constipation or overflow incontinence	F98.1 Nonorganic encopresis	
6C01.Z Encopresis, unspecified	F98.1 Nonorganic encopresis	
6C0Z Elimination disorder, unspecified	F98.1 Nonorganic encopresis	
Disorders of bodily distress or bodily experience		
6C20 Bodily distress disorder	F45.9 Somatoform disorder, unspecified-	
6C20.0 Mild bodily distress disorder	F45.4 Persistent somatoform pain disorder OR F45.9 Somatoform disorder, unspecified	Use F45.4 if the primary symptom is pain.
6C20.1 Moderate bodily distress disorder	F45.4 Persistent somatoform pain disorder OR F45.9 Somatoform disorder, unspecified	Use F45.4 if the primary symptom is pain.
6C20.2 Severe bodily distress disorder	F45.0 Somatization disorder OR F45.4 Persistent somatoform pain disorder OR F45.9 Somatoform disorder, unspecified	Use F45.4 if the primary symptom is pain. Use F45.0 if there is a history of multiple and variable bodily symptoms.
6C20.Z Bodily distress disorder, unspecified	F45.9 Somatoform disorder, unspecified	
6C21 Body integrity dysphoria	F99 Unspecified mental disorder	

ICD-11	ICD-10	Notes
6C2Y Other specified disorder of bodily distress or bodily experience	F99 Unspecified mental disorder No 4-character code available	
6C2Z Disorder of bodily distress or bodily experience, unspecified	F99 Unspecified mental disorder No 4-character code available	
Disorders due to substance use or addictive behaviours		
Disorders due to substance use		
6C40 Disorders due to use of alcohol	F10 Mental and behavioural disorders due to use of alcohol	
6C40.0 Episode of harmful use of alcohol	F10.8 Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders	
6C40.1 Harmful pattern of use of alcohol	F10.1 Mental and behavioural disorders due to use of alcohol: harmful use	
6C40.10 Harmful pattern of use of alcohol, episodic	F10.1 Mental and behavioural disorders due to use of alcohol: harmful use	
6C40.11 Harmful pattern of use of alcohol, continuous	F10.1 Mental and behavioural disorders due to use of alcohol: harmful use	
6C40.1Z Harmful pattern of use of alcohol, unspecified	F10.1 Mental and behavioural disorders due to use of alcohol: harmful use	
6C40.2 Alcohol dependence	F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.20 Alcohol dependence, current use, continuous	F10.25 Mental and behavioural disorders due to use of alcohol: dependence syndrome, continuous use 4-character code: F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.21 Alcohol dependence, current use, episodic	F10.26 Mental and behavioural disorders due to use of alcohol: dependence syndrome episodic use 4-character code: F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.22 Alcohol dependence, early full remission	F10.20 Mental and behavioural disorders due to use of alcohol: dependence syndrome, currently abstinent OR F10.21 Mental and behavioural disorders due to use of alcohol: dependence syndrome, currently abstinent, but in a protected environment OR F10.23 Mental and behavioural disorders due to use of alcohol: dependence syndrome, currently abstinent, but receiving treatment with aversive or blocking drugs (e.g. naltrexone or disulfiram) 4-character code: F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	Select the appropriate category based on clinical context.

ICD-11	ICD-10	Notes
6C40.23 Alcohol dependence, sustained partial remission	F10.24 Mental and behavioural disorders due to use of alcohol: dependence syndrome, currently using the substance [active dependence] 4-character code: F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.24 Alcohol dependence, sustained full remission	F10.20 Mental and behavioural disorders due to use of alcohol: dependence syndrome, currently abstinent 4-character code: F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.2Z Alcohol dependence, unspecified	F10.2 Mental and behavioural disorders due to use of alcohol: dependence syndrome	
6C40.3 Alcohol intoxication	F10.0 Mental and behavioural disorders due to use of alcohol: acute intoxication	
6C40.4 Alcohol withdrawal	F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.40 Alcohol withdrawal, uncomplicated	F10.30 Mental and behavioural disorders due to use of alcohol withdrawal state, uncomplicated 4-character code: F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.41 Alcohol withdrawal with perceptual disturbances	F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.42 Alcohol withdrawal with seizures	F10.31 Mental and behavioural disorders due to use of alcohol withdrawal state, with convulsions 4-character code: F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.43 Alcohol withdrawal with perceptual disturbances and seizures	F10.31 Mental and behavioural disorders due to use of alcohol withdrawal state, with convulsions 4-character code: F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.4Z Alcohol withdrawal, unspecified	F10.3 Mental and behavioural disorders due to use of alcohol withdrawal state	
6C40.5 Alcohol-induced delirium	F10.03 Mental and behavioural disorders due to use of alcohol: acute intoxication with delirium 4-character code: F10.0 Mental and behavioural disorders due to use of alcohol: acute intoxication OR F10.4 Mental and behavioural disorders due to use of alcohol withdrawal state with delirium OR F10.8 Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders	Use F10.8 if intoxication/ withdrawal status is unknown.

ICD-11	ICD-10	Notes
6C40.6 Alcohol-induced psychotic disorder	F10.5 Mental and behavioural disorders due to use of alcohol: psychotic disorder	
6C40.60 Alcohol-induced psychotic disorder with hallucinations	F10.52 Mental and behavioural disorders due to use of alcohol: psychotic disorder, predominantly hallucinatory (includes alcoholic hallucinosis) 4-character code: F10.5 Mental and behavioural disorders due to use of alcohol: psychotic disorder	
6C40.61 Alcohol-induced psychotic disorder with delusions	F10.51 Mental and behavioural disorders due to use of alcohol: psychotic disorder, predominantly delusional 4-character code: F10.5 Mental and behavioural disorders due to use of alcohol: psychotic disorder	
6C40.62 Alcohol-induced psychotic disorder with mixed psychotic symptoms	F10.56 Mental and behavioural disorders due to use of alcohol: psychotic disorder, mixed 4-character code: F10.5 Mental and behavioural disorders due to use of alcohol: psychotic disorder	
6C40.6Z Alcohol-induced psychotic disorder, unspecified	F10.5 Mental and behavioural disorders due to use of alcohol: psychotic disorder	
6C40.70 Alcohol-induced mood disorder	F10.8 Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders	
6C40.71 Alcohol-induced anxiety disorder	F10.8 Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders	
6C40.Y Other specified disorder due to use of alcohol	F10.8 Mental and behavioural disorders due to use of alcohol: other mental and behavioural disorders	
6C40.Z Disorder due to use of alcohol, unspecified	F10.9 Mental and behavioural disorders due to use of alcohol: unspecified mental and behavioural disorder	
6C41 Disorders due to use of cannabis	F12 Mental and behavioural disorders due to use of cannabinoids	
6C41.0 Episode of harmful use of cannabis	F12.8 Mental and behavioural disorders due to use of cannabinoids: other mental and behavioural disorders	
6C41.1 Harmful pattern of use of cannabis	F12.1 Mental and behavioural disorders due to use of cannabinoids: harmful use	
6C41.10 Harmful pattern of use of cannabis, episodic	F12.1 Mental and behavioural disorders due to use of cannabinoids: harmful use	
6C41.11 Harmful pattern of use of cannabis, continuous	F12.1 Mental and behavioural disorders due to use of cannabinoids: harmful use	
6C41.1Z Harmful pattern of use of cannabis, unspecified	F12.1 Mental and behavioural disorders due to use of cannabinoids: harmful use	
6C41.2 Cannabis dependence	F12.2 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome	

ICD-11	ICD-10	Notes
6C41.20 Cannabis dependence, current use	F12.24 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome, currently using the substance [active dependence] 4-character code: F12.2 Mental Behavioural disorders due to use of cannabinoids: dependence syndrome	
6C41.21 Cannabis dependence, early full remission	F12.20 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome, currently abstinent OR F12.21 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome, currently abstinent but in a protected environment 4-character code: F12.2 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome	Select the appropriate category based on clinical context.
6C41.22 Cannabis dependence, sustained partial remission	F12.24 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome, currently using the substance [active dependence] 4-character code: F12.2 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome	
6C41.23 Cannabis dependence, sustained full remission	F12.20 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome, currently abstinent 4-character code: F12.2 Mental and behavioural disorders due to use of cannabinoids: dependence syndrome	
6C41.2Z Cannabis dependence, unspecified	F12.9 Mental and behavioural disorders due to use of cannabinoids: unspecified mental and behavioural disorder	
6C41.3 Cannabis intoxication	F12.0 Mental and behavioural disorders due to use of cannabinoids: acute intoxication	
6C41.4 Cannabis withdrawal	F12.3 Mental and behavioural disorders due to use of cannabinoids withdrawal state	
6C41.5 Cannabis-induced delirium	F12.03 Mental and behavioural disorders due to use of cannabinoids: acute intoxication with delirium 4-character code: F12.0 Mental and behavioural disorders due to use of cannabinoids: acute intoxication OR F12.4 Mental and behavioural disorders due to use of cannabinoids withdrawal state with delirium OR F12.8 Mental and behavioural disorders due to use of cannabinoids: other mental and behavioural disorders	Use F12.8 if intoxication/ withdrawal status is unknown.

ICD-11	ICD-10	Notes
6C41.6 Cannabis-induced psychotic disorder	F12.5 Mental and behavioural disorders due to use of cannabinoids: psychotic disorder	
6C41.70 Cannabis-induced mood disorder	F12.8 Mental and behavioural disorders due to use of cannabinoids: other mental and behavioural disorders	
6C41.71 Cannabis-induced anxiety disorder	F12.8 Mental and behavioural disorders due to use of cannabinoids: other mental and behavioural disorders	
6C41.Y Other specified disorder due to use of cannabis	F12.8 Mental and behavioural disorders due to use of cannabinoids: other mental and behavioural disorders	
6C41.Z Disorder due to use of cannabis, unspecified	F12.9 Mental and behavioural disorders due to use of cannabinoids: unspecified mental and behavioural disorder	
6C42 Disorders due to use of synthetic cannabinoids	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C42.0 Episode of harmful use of synthetic cannabinoids	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C42.1 Harmful pattern of use of synthetic cannabinoids	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C42.10 Harmful pattern of use of synthetic cannabinoids, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C42.11 Harmful pattern of use of synthetic cannabinoids, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C42.1Z Harmful pattern of use of synthetic cannabinoids, unspecified	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C42.2 Synthetic cannabinoid dependence	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C42.20 Synthetic cannabinoid dependence, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C42.21 Synthetic cannabinoid dependence, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C42.22 Synthetic cannabinoid dependence, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	

ICD-11	ICD-10	Notes
6C42.23 Synthetic cannabinoid dependence, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C42.2Z Synthetic cannabinoid dependence, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C42.3 Synthetic cannabinoid intoxication	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C42.4 Synthetic cannabinoid withdrawal	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C42.5 Synthetic cannabinoid-induced delirium	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	Use F19.8 if intoxication/ withdrawal status is unknown.
6C42.6 Synthetic cannabinoid-induced psychotic disorder	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C42.70 Synthetic cannabinoid-induced mood disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C42.71 Synthetic cannabinoid-induced anxiety disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C42.Y Other specified disorder due to use of synthetic cannabinoids	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C42.Z Disorder due to use of synthetic cannabinoids, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C43 Disorders due to use of opioids	F11 Mental and behavioural disorders due to use of opioids	
6C43.0 Episode of harmful use of opioids	F11.8 Mental and behavioural disorders due to use of opioids: other mental and behavioural disorders	
6C43.1 Harmful pattern of use of opioids	F11.1 Mental and behavioural disorders due to use of opioids: harmful use	
6C43.10 Harmful pattern of use of opioids, episodic	F11.1 Mental and behavioural disorders due to use of opioids: harmful use	

ICD-11	ICD-10	Notes
6C43.11 Harmful pattern of use of opioids, continuous	F11.1 Mental and behavioural disorders due to use of opioids: harmful use	
6C43.1Z Harmful pattern of use of opioids, unspecified	F11.1 Mental and behavioural disorders due to use of opioids: harmful use	
6C43.2 Opioid dependence	F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	
6C43.20 Opioid dependence, current use	F11.24 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently using the substance [active dependence] 4-character code: F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	
6C43.21 Opioid dependence, early full remission	F11.20 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently abstinent OR F11.21 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently abstinent, but in a protected environment OR F11.23 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently abstinent, but receiving treatment with aversive or blocking drugs (e.g. naltrexone or disulfiram) 4-character code: F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	Select the appropriate category based on clinical context.
6C43.22 Opioid dependence, sustained partial remission	F11.24 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently using the substance [active dependence] 4-character code: F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	
6C43.23 Opioid dependence, sustained full remission	F11.20 Mental and behavioural disorders due to use of opioids: dependence syndrome, currently abstinent 4-character code: F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	
6C43.2Z Opioid dependence, unspecified	F11.2 Mental and behavioural disorders due to use of opioids: dependence syndrome	
6C43.3 Opioid intoxication	F11.0 Mental and behavioural disorders due to use of opioids: acute intoxication	
6C43.4 Opioid withdrawal	F11.3 Mental and behavioural disorders due to use of opioids withdrawal state	

ICD-11	ICD-10	Notes
6C43.5 Opioid-induced delirium	F11.03 Mental and behavioural disorders due to use of opioids: acute intoxication with delirium 4-character code: F11.0 Mental and behavioural disorders due to use of opioids: acute intoxication OR F11.4 Mental and behavioural disorders due to use of opioids withdrawal state with delirium OR F11.8 Mental and behavioural disorders due to use of opioids: other mental and behavioural disorders	Use F11.8 if intoxication/ withdrawal status is unknown.
6C43.6 Opioid-induced psychotic disorder	F11.5 Mental and behavioural disorders due to use of opioids: psychotic disorder	
6C43.70 Opioid-induced mood disorder	F11.8 Mental and behavioural disorders due to use of opioids: other mental and behavioural disorders	
6C43.71 Opioid-induced anxiety disorder	F11.8 Mental and behavioural disorders due to use of opioids: other mental and behavioural disorders	
6C43.Y Other specified disorder due to use of opioids	F11.8 Mental and behavioural disorders due to use of opioids: other mental and behavioural disorders	
6C43.Z Disorder due to use of opioids, unspecified	F11.9 Mental and behavioural disorders due to use of opioids: unspecified mental and behavioural disorder	
6C44 Disorders due to use of sedatives, hypnotics or anxiolytics	F13 Mental and behavioural disorders due to use of sedatives or hypnotics	
6C44.0 Episode of harmful use of sedatives, hypnotics or anxiolytics	F13.8 Mental and behavioural disorders due to use of sedatives or hypnotics: other mental and behavioural disorders	
6C44.1 Harmful pattern of use of sedatives, hypnotics or anxiolytics	F13.1 Mental and behavioural disorders due to use of sedatives or hypnotics: harmful use	
6C44.10 Harmful pattern of use of sedatives, hypnotics or anxiolytics, episodic	F13.1 Mental and behavioural disorders due to use of sedatives or hypnotics: harmful use	
6C44.11 Harmful pattern of use of sedatives, hypnotics or anxiolytics, continuous	F13.1 Mental and behavioural disorders due to use of sedatives or hypnotics: harmful use	
6C44.1Z Harmful pattern of use of sedatives, hypnotics or anxiolytics, unspecified	F13.1 Mental and behavioural disorders due to use of sedatives or hypnotics: harmful use	
6C44.2 Sedative, hypnotic or anxiolytic dependence	F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	
6C44.20 Sedative, hypnotic or anxiolytic dependence, current use	F13.24 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome, currently using the substance [active dependence] 4-character code: F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	

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6C44.21 Sedative, hypnotic or anxiolytic dependence, early full remission	F13.20 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome, currently abstinent OR F13.21 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	Select the appropriate category based on clinical context.
6C44.22 Sedative, hypnotic or anxiolytic dependence, sustained partial remission	F13.24 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome, currently using the substance [active dependence] 4-character code: F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	
6C44.23 Sedative, hypnotic or anxiolytic dependence, sustained full remission	F13.20 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome, currently abstinent 4-character code: F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	
6C44.2Z Sedative, hypnotic or anxiolytic dependence, unspecified	F13.2 Mental and behavioural disorders due to use of sedatives or hypnotics: dependence syndrome	
6C44.3 Sedative, hypnotic or anxiolytic intoxication	F13.0 Mental and behavioural disorders due to use of sedatives or hypnotics: acute intoxication	
6C44.4 Sedative, hypnotic or anxiolytic withdrawal	F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	
6C44.40 Sedative, hypnotic or anxiolytic withdrawal, uncomplicated	F13.30 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state, uncomplicated 4-character code: F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	
6C44.41 Sedative, hypnotic or anxiolytic withdrawal, with perceptual disturbances	F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	
6C44.42 Sedative, hypnotic or anxiolytic withdrawal, with seizures	F13.31 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state, with convulsions 4-character code: F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	
6C44.43 Sedative, hypnotic or anxiolytic withdrawal, with perceptual disturbances and seizures	F13.31 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state, with convulsions 4-character code: F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	
6C44.4Z Sedative, hypnotic or anxiolytic withdrawal, unspecified	F13.3 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state	

ICD-11	ICD-10	Notes
6C44.5 Sedative, hypnotic or anxiolytic-induced delirium	F13.03 Mental and behavioural disorders due to use of sedatives or hypnotics: acute intoxication with delirium 4-character code: F13.0 Mental and behavioural disorders due to use of sedatives or hypnotics: acute intoxication OR F13.4 Mental and behavioural disorders due to use of sedatives or hypnotics withdrawal state with delirium OR F13.8 Mental or behavioural disorders due to use of sedatives or hypnotics: other mental and behavioural disorders	Use F13.8 if intoxication/ withdrawal status is unknown.
6C44.6 Sedative, hypnotic or anxiolytic-induced psychotic disorder	F13.5 Mental and behavioural disorders due to use of sedatives or hypnotics: psychotic disorder	
6C44.70 Sedative, hypnotic or anxiolytic-induced mood disorder	F13.8 Mental and behavioural disorders due to use of sedatives or hypnotics: other mental and behavioural disorders	
6C44.71 Sedative, hypnotic or anxiolytic-induced anxiety disorder	F13.8 Mental and behavioural disorders due to use of sedatives or hypnotics: other mental and behavioural disorders	
6C44.Y Other specified disorder due to use of sedatives, hypnotics or anxiolytics	F13.8 Mental and behavioural disorders due to use of sedatives or hypnotics: other mental and behavioural disorders	
6C44.Z Disorder due to use of sedatives, hypnotics or anxiolytics, unspecified	F13.9 Mental and behavioural disorders due to use of sedatives or hypnotics: unspecified mental and behavioural disorder	
6C45 Disorders due to use of cocaine	F14 Mental and behavioural disorders due to use of cocaine	
6C45.0 Episode of harmful use of cocaine	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.1 Harmful pattern of use of cocaine	F14.1 Mental and behavioural disorders due to use of cocaine: harmful use	
6C45.10 Harmful pattern of use of cocaine, episodic	F14.1 Mental and behavioural disorders due to use of cocaine: harmful use	
6C45.11 Harmful pattern of use of cocaine, continuous	F14.1 Mental and behavioural disorders due to use of cocaine: harmful use	
6C45.1Z Harmful pattern of use of cocaine, unspecified	F 14.1 Mental and behavioural disorders due to use of cocaine: harmful use	
6C45.2 Cocaine dependence	F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	
6C45.20 Cocaine dependence, current use	F14.24 Mental and behavioural disorders due to use of cocaine: dependence syndrome, currently using the substance [active dependence] 4-character code: F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	
6C45.21 Cocaine dependence, early full remission	F14.20 Mental and behavioural disorders due to use of cocaine: dependence syndrome, currently abstinent OR F14.21 Mental and behavioural disorders due to use of cocaine: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	Select the appropriate category based on clinical context.

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6C45.22 Cocaine dependence, sustained partial remission	F14.23 Mental and behavioural disorders due to use of cocaine: dependence syndrome, currently using the substance [active dependence] 4-character code: F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	
6C45.23 Cocaine dependence, sustained full remission	F14.20 Mental and behavioural disorders due to use of cocaine: dependence syndrome, currently abstinent 4-character code: F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	
6C45.2Z Cocaine dependence, unspecified	F14.2 Mental and behavioural disorders due to use of cocaine: dependence syndrome	
6C45.3 Cocaine intoxication	F14.0 Mental and behavioural disorders due to use of cocaine: acute intoxication	
6C45.4 Cocaine withdrawal	F14.3 Mental and behavioural disorders due to use of cocaine withdrawal state	
6C45.5 Cocaine-induced delirium	F14.03 Mental and behavioural disorders due to use of cocaine: acute intoxication with delirium 4-character code: F14.0 Mental and behavioural disorders due to use of cocaine: acute intoxication OR F14.4 Mental and behavioural disorders due to use of cocaine withdrawal state with delirium OR F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	Use F14.8 if intoxication/ withdrawal status is unknown.
6C45.6 Cocaine-induced psychotic disorder	F14.5 Mental and behavioural disorders due to use of cocaine: psychotic disorder	
6C45.60 Cocaine-induced psychotic disorder with hallucinations	F14.52 Mental and behavioural disorders due to use of cocaine: psychotic disorder, predominantly hallucinatory 4-character code: F14.5 Mental and behavioural disorders due to use of cocaine: psychotic disorder	
6C45.61 Cocaine-induced psychotic disorder with delusions	F14.51 Mental and behavioural disorders due to use of cocaine: psychotic disorder, predominantly delusional 4-character code: F14.5 Mental and behavioural disorders due to use of cocaine: psychotic disorder	
6C45.62 Cocaine-induced psychotic disorder with mixed psychotic symptoms	F14.56 Mental and behavioural disorders due to use of cocaine: psychotic disorder, mixed 4-character code: F14.5 Mental and behavioural disorders due to use of cocaine: psychotic disorder	

ICD-11	ICD-10	Notes
6C45.6Z Cocaine-induced psychotic disorder, unspecified	F14.5 Mental and behavioural disorders due to use of cocaine: psychotic disorder	
6C45.70 Cocaine-induced mood disorder	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.71 Cocaine-induced anxiety disorder	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.72 Cocaine-induced obsessive-compulsive or related disorder	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.73 Cocaine-induced impulse control disorder	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.Y Other specified disorder due to use of cocaine	F14.8 Mental and behavioural disorders due to use of cocaine: other mental and behavioural disorders	
6C45.Z Disorder due to use of cocaine, unspecified	F14.9 Mental and behavioural disorders due to use of cocaine: unspecified mental and behavioural disorder	
6C46 Disorders due to use of stimulants, including amfetamines, methamfetamine and methcathinone	F15 Mental and behavioural disorders due to use of other stimulants, including caffeine	
6C46.0 Episode of harmful use of stimulants, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.1 Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C46.10 Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone, episodic	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C46.11 Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone, continuous	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C46.1Z Harmful pattern of use of stimulants, including amfetamines, methamfetamine and methcathinone, unspecified	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C46.2 Stimulant dependence, including amfetamines, methamfetamine and methcathinone	F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome	
6C46.20 Stimulant dependence, including amfetamines, methamfetamine and methcathinone, current use	F15.24 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome, currently using the substance [active substance] 4-character code: F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome	
6C46.21 Stimulant dependence, including amfetamines, methamfetamine and methcathinone, early full remission	F15.20 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome, currently abstinent OR F15.21 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome	Select the appropriate category based on clinical context.

ICD-11	ICD-10	Notes
6C46.22 Stimulant dependence, including amfetamines, methamfetamine and methcathinone, sustained partial remission	F15.24 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome, currently using the substance [active dependence] 4-character code: F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome	
6C46.23 Stimulant dependence, including amfetamines, methamfetamine and methcathinone, sustained full remission	F15.20 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome, currently abstinent 4-character code: F15.2 Mental and behavioural disorders due to use of other stimulants, including caffeine: dependence syndrome	
6C46.2Z Stimulant dependence, including amfetamines, methamfetamine and methcathinone, unspecified	F15.9 Mental and behavioural disorders due to use of other stimulants, including caffeine: unspecified mental and behavioural disorder	
6C46.3 Stimulant intoxication, including amfetamines, methamfetamine and methcathinone	F15.0 Mental and behavioural disorders due to use of other stimulants, including caffeine: acute intoxication	
6C46.4 Stimulant withdrawal, including amfetamines, methamfetamine and methcathinone	F15.3 Mental and behavioural disorders due to use of other stimulants, including caffeine withdrawal state	
6C46.5 Stimulant-induced delirium, including amfetamines, methamfetamine and methcathinone	F15.03 Mental and behavioural disorders due to use of other stimulants, including caffeine: acute intoxication with delirium 4-character code: F15.0 Mental and behavioural disorders due to use of other stimulants, including caffeine: acute intoxication OR F15.4 Mental and behavioural disorders due to use of other stimulants, including caffeine withdrawal state with delirium OR F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	Use F15.8 if intoxication/ withdrawal status is unknown.
6C46.6 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone	F15.5 Mental and behavioural disorders due to use of other stimulants, including caffeine: psychotic disorder	
6C46.60 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone with hallucinations	F15.52 Mental and behavioural disorders due to use of other stimulants, including caffeine: psychotic disorder, predominantly hallucinatory 4-character code: F15.5 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.61 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone with delusions	F15.51 Mental and behavioural disorders due to use of other stimulants, including caffeine: psychotic disorder, predominantly delusional 4-character code: F15.5 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	

ICD-11	ICD-10	Notes
6C46.62 Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone with mixed psychotic symptoms	F15.56 Mental and behavioural disorders due to use of other stimulants, including caffeine: psychotic disorder, mixed 4-character code: F15.5 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.6Z Stimulant-induced psychotic disorder, including amfetamines, methamfetamine and methcathinone, unspecified	F15.5 Mental and behavioural disorders due to use of other stimulants, including caffeine: psychotic disorder	
6C46.70 Stimulant-induced mood disorder, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.71 Stimulant-induced anxiety disorder, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.72 Stimulant-induced obsessive-compulsive or related disorder, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.73 Stimulant-induced impulse control disorder, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.Y Other specified disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C46.Z Disorder due to use of stimulants, including amfetamines, methamfetamine and methcathinone, unspecified	F15.9 Mental and behavioural disorders due to use of other stimulants, including caffeine: unspecified mental and behavioural disorder	
6C47 Disorders due to use of synthetic cathinones	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C47.0 Episode of harmful use of synthetic cathinones	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.1 Harmful pattern of use of synthetic cathinones	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C47.10 Harmful pattern of use of synthetic cathinones, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C47.11 Harmful use of synthetic cathinones, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C47.1Z Harmful pattern of use of synthetic cathinones, unspecified	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C47.2 Synthetic cathinone dependence	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C47.20 Synthetic cathinone dependence, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	

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6C47.21 Synthetic cathinone dependence, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C47.22 Synthetic cathinone dependence, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C47.23 Synthetic cathinone dependence, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C47.2Z Synthetic cathinone dependence, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C47.3 Synthetic cathinone intoxication	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C47.4 Synthetic cathinone withdrawal	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	Use F19.8 if intoxication/ withdrawal status is unknown.
6C47.5 Synthetic cathinone-induced delirium	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.6 Synthetic cathinone-induced psychotic disorder	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	

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6C47.60 Synthetic cathinone-induced psychotic disorder with hallucinations	F19.52 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder, predominantly hallucinatory 4-character code: F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C47.61 Synthetic cathinone-induced psychotic disorder with delusions	F19.51 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder, predominantly delusional 4-character code: F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C47.62 Synthetic cathinone-induced psychotic disorder with mixed psychotic symptoms	F19.56 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder, mixed 4-character code: F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C47.6Z Synthetic cathinone-induced psychotic disorder, unspecified	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C47.70 Synthetic cathinone-induced mood disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.71 Synthetic cathinone-induced anxiety disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.72 Synthetic cathinone-induced obsessive-compulsive or related syndrome	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.73 Synthetic cathinone-induced impulse control disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.Y Other specified disorder due to use of synthetic cathinones	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C47.Z Disorder due to use of synthetic cathinones, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C48 Disorders due to use of caffeine	F15 Mental and behavioural disorders due to use of other stimulants, including caffeine	
6C48.0 Episode of harmful use of caffeine	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C48.1 Harmful pattern of use of caffeine	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C48.10 Harmful pattern of use of caffeine, episodic	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C48.11 Harmful pattern of use of caffeine, continuous	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C48.1Z Harmful pattern of use of caffeine, unspecified	F15.1 Mental and behavioural disorders due to use of other stimulants, including caffeine: harmful use	
6C48.2 Caffeine intoxication	F15.0 Mental and behavioural disorders due to use of other stimulants, including caffeine: acute intoxication	

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6C48.3 Caffeine withdrawal	F15.3 Mental and behavioural disorders due to use of other stimulants, including caffeine withdrawal state	
6C48.40 Caffeine-induced anxiety disorder	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C48.Y Other specified disorder due to use of caffeine	F15.8 Mental and behavioural disorders due to use of other stimulants, including caffeine: other mental and behavioural disorders	
6C48.Z Disorder due to use of caffeine, unspecified	F15.9 Mental and behavioural disorders due to use of other stimulants, including caffeine: unspecified mental and behavioural disorder	
6C49 Disorders due to use of hallucinogens	F16 Mental and behavioural disorders due to use of hallucinogens	
6C49.0 Episode of harmful use of hallucinogens	F16.8 Mental and behavioural disorders due to use of hallucinogens: other mental and behavioural disorders	
6C49.1 Harmful pattern of use of hallucinogens	F16.1 Mental and behavioural disorders due to use of hallucinogens: harmful use	
6C49.10 Harmful pattern of use of hallucinogens, episodic	F16.1 Mental and behavioural disorders due to use of hallucinogens: harmful use	
6C49.11 Harmful pattern of use of hallucinogens, continuous	F16.1 Mental and behavioural disorders due to use of hallucinogens: harmful use	
6C49.1Z Harmful pattern of use of hallucinogens, unspecified	F16.1 Mental and behavioural disorders due to use of hallucinogens: harmful use	
6C49.2 Hallucinogen dependence	F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	
6C49.20 Hallucinogen dependence, current use	F16.24 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome, currently using the substance [active dependence] 4-character code: F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	
6C49.21 Hallucinogen dependence, early full remission	F16.20 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome, currently abstinent OR F16.21 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	Select the appropriate category based on clinical context.
6C49.22 Hallucinogen dependence, sustained partial remission	F16.24 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome, currently using the substance [active dependence] 4-character code: F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	
6C49.23 Hallucinogen dependence, sustained full remission	F16.20 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome, currently abstinent 4-character code: F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	

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6C49.2Z Hallucinogen dependence, unspecified	F16.2 Mental and behavioural disorders due to use of hallucinogens: dependence syndrome	
6C49.3 Hallucinogen intoxication	F16.0 Mental and behavioural disorders due to use of hallucinogens: acute intoxication	
6C49.4 Hallucinogen-induced delirium	F16.03 Mental and behavioural disorders due to use of hallucinogens: acute intoxication with delirium 4-character code: F16.0 Mental and behavioural disorders due to use of hallucinogens: acute intoxication OR F16.8 Mental and behavioural disorders due to use of hallucinogens: other mental and behavioural disorders	Use F16.8 if intoxication status is unknown.
6C49.5 Hallucinogen-induced psychotic disorder	F16.5 Mental and behavioural disorders due to use of hallucinogens: psychotic disorder	
6C49.60 Hallucinogen-induced mood disorder	F16.8 Mental and behavioural disorders due to use of hallucinogens: other mental and behavioural disorders	
6C49.61 Hallucinogen-induced anxiety disorder	F16.8 Mental and behavioural disorders due to use of hallucinogens: other mental and behavioural disorders	
6C49.Y Other specified disorder due to use of hallucinogens	F16.8 Mental and behavioural disorders due to use of hallucinogens: other mental and behavioural disorders	
6C49.Z Disorder due to use of hallucinogens, unspecified	F16.9 Mental and behavioural disorders due to use of hallucinogens: unspecified mental and behavioural disorder	
6C4A Disorders due to use of nicotine	F17 Mental and behavioural disorders due to use of tobacco	
6C4A.0 Episode of harmful use of nicotine	F17.8 Mental and behavioural disorders due to use of tobacco: other mental and behavioural disorders	
6C4A.1 Harmful pattern of use of nicotine	F17.1 Mental and behavioural disorders due to use of tobacco: harmful use	
6C4A.10 Harmful pattern of use of nicotine, episodic	F17.1 Mental and behavioural disorders due to use of tobacco: harmful use	
6C4A.11 Harmful pattern of use of nicotine, continuous	F17.1 Mental and behavioural disorders due to use of tobacco: harmful use	
6C4A.1Z Harmful pattern of use of nicotine, unspecified	F17.1 Mental and behavioural disorders due to use of tobacco: harmful use	
6C4A.2 Nicotine dependence	F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	
6C4A.20 Nicotine dependence, current use	F17.24 Mental and behavioural disorders due to use of tobacco: dependence syndrome, currently using the substance [active dependence] 4-character code: F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	
6C4A.21 Nicotine dependence, early full remission	F17.20 Mental and behavioural disorders due to use of tobacco: dependence syndrome, currently abstinent OR F17.21 Mental and behavioural disorders due to use of tobacco: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	Select the appropriate category based on clinical context.

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6C4A.22 Nicotine dependence, sustained partial remission	F17.24 Mental and behavioural disorders due to use of tobacco: dependence syndrome, currently using the substance [active dependence] 4-character code: F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	
6C4A.23 Nicotine dependence, sustained full remission	F17.20 Mental and behavioural disorders due to use of tobacco: dependence syndrome, currently abstinent 4-character code: F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	
6C4A.2Z Nicotine dependence, unspecified	F17.2 Mental and behavioural disorders due to use of tobacco: dependence syndrome	
6C4A.3 Nicotine intoxication	F17.0 Mental and behavioural disorders due to use of tobacco: acute intoxication	
6C4A.4 Nicotine withdrawal	F17.3 Mental and behavioural disorders due to use of tobacco withdrawal state	
6C4A.Y Other specified disorder due to use of nicotine	F17.3 Mental and behavioural disorders due to use of tobacco withdrawal state	
6C4A.Z Disorder due to use of nicotine, unspecified	F17.3 Mental and behavioural disorders due to use of tobacco withdrawal state	
6C4B Disorders due to use of volatile inhalants	F18 Mental and behavioural disorders due to use of volatile solvents	
6C4B.0 Episode of harmful use of volatile inhalants	F18.8 Mental and behavioural disorders due to use of volatile solvents: other mental and behavioural disorders	
6C4B.1 Harmful pattern of use of volatile inhalants	F18.1 Mental and behavioural disorders due to use of volatile solvents: harmful use	
6C4B.10 Harmful pattern of use of volatile inhalants, episodic	F18.1 Mental and behavioural disorders due to use of volatile solvents: harmful use	
6C4B.11 Harmful pattern of use of volatile inhalants, continuous	F18.1 Mental and behavioural disorders due to use of volatile solvents: harmful use	
6C4B.1Z Harmful pattern of use of volatile inhalants, unspecified	F18.1 Mental and behavioural disorders due to use of volatile solvents: harmful use	
6C4B.2 Volatile inhalant dependence	F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	
6C4B.20 Volatile inhalant dependence, current use	F18.24 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome, currently using the substance [active dependence] 4-character code: F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	
6C4B.21 Volatile inhalant dependence, early full remission	F18.20 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome, currently abstinent OR F18.21 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	Select the appropriate category based on clinical context.

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6C4B.22 Volatile inhalant dependence, sustained partial remission	F18.24 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome, currently using the substance [active dependence] 4-character code: F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	
6C4B.23 Volatile inhalant dependence, sustained full remission	F18.20 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome, currently abstinent 4-character code: F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	
6C4B.2Z Volatile inhalant dependence, unspecified	F18.2 Mental and behavioural disorders due to use of volatile solvents: dependence syndrome	
6C4B.3 Volatile inhalant intoxication	F18.0 Mental and behavioural disorders due to use of volatile solvents: acute intoxication	
6C4B.4 Volatile inhalant withdrawal	F18.3 Mental and behavioural disorders due to use of volatile solvents withdrawal state	
6C4B.5 Volatile inhalant-induced delirium	F18.03 Mental and behavioural disorders due to use of volatile solvents: acute intoxication with delirium 4-character code: F18.0 Mental and behavioural disorders due to use of volatile solvents: acute intoxication OR F18.4 Mental and behavioural disorders due to use of volatile solvents withdrawal state with delirium OR F18.8 Mental and behavioural disorders due to use of volatile solvents: other mental and behavioural disorders	Use F18.8 if intoxication/ withdrawal status is unknown.
6C4B.6 Volatile inhalant-induced psychotic disorder	F18.5 Mental and behavioural disorders due to use of volatile solvents: psychotic disorder	
6C4B.70 Volatile inhalant-induced mood disorder	F18.8 Mental and behavioural disorders due to use of volatile solvents: other mental and behavioural disorders	
6C4B.71 Volatile inhalant-induced anxiety disorder	F18.8 Mental and behavioural disorders due to use of volatile solvents: other mental and behavioural disorders	
6C4B.Y Other specified disorder due to use of volatile inhalants	F18.8 Mental and behavioural disorders due to use of volatile solvents: other mental and behavioural disorders	
6C4B.Z Disorder due to use of volatile inhalants, unspecified	F18.9 Mental and behavioural disorders due to use of volatile solvents: unspecified mental and behavioural disorder	
6C4C Disorders due to use of MDMA or related drugs, including MDA	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C4C.0 Episode of harmful use of MDMA or related drugs, including MDA	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4C.1 Harmful pattern of use of MDMA or related drugs, including MDA	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4C.10 Harmful use of MDMA or related drugs, including MDA, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4C.11 Harmful use of MDMA or related drugs, including MDA, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4C.1Z Harmful pattern of use of MDMA or related drugs, including MDA, unspecified	F19.1 Mental and behavioural disorders due to multiple drug us and use of other psychoactive substances: harmful use	

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6C4C.2 MDMA or related drug dependence, including MDA	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4C.20 MDMA or related drug dependence, including MDA, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4C.21 MDMA or related drug dependence, including MDA, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C4C.22 MDMA or related drug dependence, including MDA, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4C.23 MDMA or related drug dependence, including MDA, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4C.2Z MDMA or related drug dependence, including MDA, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4C.3 MDMA or related drug intoxication, including MDA	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C4C.4 MDMA or related drug withdrawal, including MDA	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	

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6C4C.5 MDMA or related drug-induced delirium, including MDA	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	Use F19.8 if intoxication/ withdrawal status is unknown.
6C4C.6 MDMA or related drug-induced psychotic disorder, including MDA	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C4C.70 MDMA or related drug-induced mood disorder, including MDA	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4C.71 MDMA or related drug-induced anxiety disorder	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4C.Y Other specified disorder due to use of MDMA or related drugs, including MDA	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4C.Z Disorder due to use of MDMA or related drugs, including MDA, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C4D Disorders due to use of dissociative drugs, including ketamine and phencyclidine (PCP)	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C4D.0 Episode of harmful use of dissociative drugs, including ketamine and PCP	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4D.1 Harmful pattern of use of dissociative drugs, including ketamine and PCP	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4D.10 Harmful pattern of use of dissociative drugs, including ketamine and PCP, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4D.11 Harmful pattern of use of dissociative drugs, including ketamine and PCP, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4D.1Z Harmful pattern of use of dissociative drugs, including ketamine and PCP, unspecified	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4D.2 Dissociative drug dependence, including ketamine and PCP	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4D.20 Dissociative drug dependence, including ketamine and PCP, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	

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6C4D.21 Dissociative drug dependence, including ketamine and PCP, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C4D.22 Dissociative drug dependence, including ketamine and PCP, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4D.23 Dissociative drug dependence, including ketamine and PCP, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4D.2Z Dissociative drug dependence, including ketamine and PCP, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4D.3 Dissociative drug intoxication, including ketamine and PCP	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C4D.4 Dissociative drug-induced delirium, including ketamine and PCP	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	Use F19.8 if intoxication status unknown.
6C4D.5 Dissociative drug-induced psychotic disorder, including ketamine and PCP	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	

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6C4D.60 Dissociative drug-induced mood disorder, including ketamine and PCP	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4D.6 Dissociative drug-induced anxiety disorder, including ketamine and PCP	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4D.Y Other specified disorder due to use of dissociative drugs, including ketamine and PCP	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4D.Z Disorder due to use of dissociative drugs, including ketamine and PCP, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C4E Disorders due to use of other specified psychoactive substances, including medications	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C4E.0 Episode of harmful use of other specified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.1 Harmful pattern of use of other specified psychoactive substance	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4E.10 Harmful pattern of use of other specified psychoactive substance, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4E.11 Harmful pattern of use of other specified psychoactive substance, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4E.1Z Harmful pattern of use of other specified psychoactive substance, unspecified	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4E.2 Other specified psychoactive substance dependence	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4E.20 Other specified psychoactive substance dependence, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4E.21 Other specified psychoactive substance dependence, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment OR F19.23 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but receiving treatment with aversive or blocking drugs (e.g. naltrexone or disulfiram) 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.

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6C4E.22 Other specified psychoactive substance dependence, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4E.23 Other specified psychoactive substance dependence, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4E.2Z Other specified psychoactive substance dependence, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4E.3 Other specified psychoactive substance intoxication	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C4E.4 Other specified psychoactive substance withdrawal	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4E.40 Other specified psychoactive substance withdrawal, uncomplicated	F19.30 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, uncomplicated 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4E.41 Other specified psychoactive substance withdrawal, with perceptual disturbances	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4E.42 Other specified psychoactive substance withdrawal, with seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4E.43 Other specified psychoactive substance withdrawal, with perceptual disturbances and seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4E.4Z Other specified psychoactive substance withdrawal, unspecified	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	

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6C4E.5 Delirium induced by other specified psychoactive substance, including medications	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	Use F19.8 if intoxication/ withdrawal status is unknown.
6C4E.6 Psychotic disorder induced by other specified psychoactive substance	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C4E.70 Mood disorder induced by other specified psychoactive substance	F19.8 Mental and behavioural disorder due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.71 Anxiety disorder induced by other specified psychoactive substance	F19.8 Mental and behavioural disorder due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.72 Obsessive-compulsive or related disorder induced by other specified psychoactive substance	F19.8 Mental and behavioural disorder due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.73 Impulse control disorder induced by other specified psychoactive substance	F19.8 Mental and behavioural disorder due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.Y Other specified disorder due to use of other specified psychoactive substance, including medications	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4E.Z Disorder due to use of other specified psychoactive substance, including medications, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C4F Disorders due to use of multiple specified psychoactive substances, including medications	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C4F.0 Episode of harmful use of multiple specified psychoactive substances	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4F.1 Harmful pattern of use of multiple specified psychoactive substances	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4F.10 Harmful pattern of use of multiple specified psychoactive substances, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4F.11 Harmful pattern of use of multiple specified psychoactive substances, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4F.1Z Harmful pattern of use of multiple specified psychoactive substances, unspecified	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4F.2 Multiple specified psychoactive substances dependence	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	

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6C4F.20 Multiple specified psychoactive substances dependence, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4F.21 Multiple specified psychoactive substances dependence, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment OR F19.23 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but receiving treatment with aversive or blocking drugs (e.g. naltrexone or disulfiram) 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C4F.22 Multiple specified psychoactive substances dependence, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4F.23 Multiple specified psychoactive substances dependence, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4F.2Z Multiple specified psychoactive substances dependence, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4F.3 Intoxication due to multiple specified psychoactive substances	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C4F.4 Multiple specified psychoactive substances withdrawal	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.40 Multiple specified psychoactive substances withdrawal, uncomplicated	F19.30 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, uncomplicated 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	

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6C4F.41 Multiple specified psychoactive substances withdrawal, with perceptual disturbances	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.42 Multiple specified psychoactive substances withdrawal, with seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.43 Multiple specified psychoactive substances withdrawal, with perceptual disturbances and seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.4Y Other specified multiple specified psychoactive substances withdrawal	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.4Z Multiple specified psychoactive substances withdrawal, unspecified	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4F.5 Delirium induced by multiple specified psychoactive substances, including medications	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	Use F19.8 if intoxication/ withdrawal status is unknown.
6C4F.6 Psychotic disorder induced by multiple specified psychoactive substances	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C4F.70 Mood disorder induced by multiple specified psychoactive substances	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4F.71 Anxiety disorder induced by multiple specified psychoactive substances	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4F.72 Obsessive-compulsive or related disorder induced by multiple specified psychoactive substances	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4F.73 Impulse control syndrome induced by multiple specified psychoactive substances	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4F.Y Other specified disorder . due to use of multiple specified psychoactive substances, including medications	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	

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6C4F.Z Disorder due to use of multiple specified psychoactive substances, including medications, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C4G Disorders due to use of unknown or unspecified psychoactive substances	F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances	
6C4G.0 Episode of harmful use of unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.1 Harmful pattern of use of unknown or unspecified psychoactive substance	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4G.10 Harmful pattern of use of unknown or unspecified psychoactive substance, episodic	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4G.11 Harmful pattern of use of unknown or unspecified psychoactive substance, continuous	F19.1 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: harmful use	
6C4G.1Z Harmful pattern of use of unknown or unspecified psychoactive substance, unspecified	F19.1 Mental and behavioural disorders due to multiple drug us and use of other psychoactive substances: harmful use	
6C4G.2 Unknown or unspecified psychoactive substance dependence	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4G.20 Unknown or unspecified psychoactive substance dependence, current use	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4G.21 Unknown or unspecified psychoactive substance dependence, early full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent OR F19.21 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent, but in a protected environment 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	Select the appropriate category based on clinical context.
6C4G.22 Unknown or unspecified psychoactive substance dependence, sustained partial remission	F19.24 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently using the substance [active dependence] 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4G.23 Unknown or unspecified psychoactive substance dependence, sustained full remission	F19.20 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome, currently abstinent 4-character code: F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	

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6C4G.2Z Unknown or unspecified psychoactive substance dependence, unspecified	F19.2 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: dependence syndrome	
6C4G.3 Intoxication due to unknown or unspecified psychoactive substance	F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication	
6C4G.4 Withdrawal due to unknown or unspecified psychoactive substance	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4G.40 Withdrawal due to unknown or unspecified psychoactive substance, uncomplicated	F19.30 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, uncomplicated 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4G.41 Withdrawal due to unknown or unspecified psychoactive substance, with perceptual disturbances	F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4G.42 Withdrawal due to unknown or unspecified psychoactive substance, with seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4G.43 Withdrawal due to unknown or unspecified psychoactive substance, with perceptual disturbances and seizures	F19.31 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state, with convulsions 4-character code: F19.3 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state	
6C4G.4Z Withdrawal due to unknown or unspecified psychoactive substance, unspecified	F19.3 Mental and behavioural disorders due to multiple drug us and use of other psychoactive substances withdrawal state	
6C4G.5 Delirium induced by unknown or unspecified psychoactive substance	F19.03 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication with delirium 4-character code: F19.0 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: acute intoxication OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium OR F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: Other mental and behavioural disorders	Use F19.8 if intoxication/ withdrawal status is unknown.

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6C4G.6 Psychotic disorder induced by unknown or unspecified psychoactive substance	F19.5 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: psychotic disorder	
6C4G.70 Mood disorder induced by unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.71 Anxiety disorder induced by unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.72 Obsessive-compulsive or related disorder induced by unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.73 Impulse control disorder induced by unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.Y Other specified disorder due to use of unknown or unspecified psychoactive substance	F19.8 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: other mental and behavioural disorders	
6C4G.Z Disorder due to use of unknown or unspecified psychoactive substance, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder	
6C4H Disorders due to use of non-psychoactive substances	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.0 Episode of harmful use of non-psychoactive substance	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.1 Harmful pattern of use of non-psychoactive substance	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.10 Harmful pattern of use of non-psychoactive substance, episodic	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.11 Harmful pattern of use of non-psychoactive substance, continuous	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.1Z Harmful pattern of use of non-psychoactive substance, unspecified	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4H.Y Other specified disorder due to use of non-psychoactive substance	F55 Abuse of non-dependence-producing substances No 4-character code available	

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6C4H.Z Disorder due to use of non-psychoactive substance, unspecified	F55 Abuse of non-dependence-producing substances No 4-character code available	
6C4Z Disorder due to substance use, unspecified	F19.9 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: unspecified mental and behavioural disorder OR F55 Abuse of non-dependence-producing substance	For non-psychoactive (i.e. non-dependence-producing) substances, use F55.
Disorders due to addictive behaviours		
6C50 Gambling disorder	F63.0 Pathological gambling	
6C50.0 Gambling disorder, predominantly offline	F63.0 Pathological gambling	
6C50.1 Gambling disorder, predominantly online	F63.0 Pathological gambling	
6C50.Z Gambling disorder, unspecified	F63.0 Pathological gambling	
6C51 Gaming disorder	F63.8 Other habit and impulse disorders	
6C51.0 Gaming disorder, predominantly online	F63.8 Other habit and impulse disorders	
6C51.1 Gaming disorder, predominantly offline	F63.8 Other habit and impulse disorders	
6C51.Z Gaming disorder, unspecified	F63.8 Other habit and impulse disorders	
6C5Y Other specified disorder due to addictive behaviours	F63.8 Other habit and impulse disorders	
6C5Z Disorder due to addictive behaviours, unspecified	F63.9 Habit and impulse disorder, unspecified	
Impulse control disorders		
6C70 Pyromania	F63.1 Pathological fire setting [pyromania]	
6C71 Kleptomania	F63.2 Pathological stealing [kleptomania]	
6C72 Compulsive sexual behaviour disorder	F63.8 Other habit and impulse disorders	
6C73 Intermittent explosive disorder	F63.8 Other habit and impulse disorders	
6C7Y Other specified impulse control disorder	F63.8 Other habit and impulse disorders	
6C7Z Impulse control disorder, unspecified	F63.9 Habit and impulse disorder, unspecified	
Disruptive behaviour and dissocial disorders		
6C90 Oppositional defiant disorder	F91.3 Oppositional defiant disorder	
6C90.0 Oppositional defiant disorder with chronic irritability-anger	F91.3 Oppositional defiant disorder	
6C90.00 Oppositional defiant disorder with chronic irritability-anger with limited prosocial emotions	F91.3 Oppositional defiant disorder	
6C90.01 Oppositional defiant disorder with chronic irritability-anger with typical prosocial emotions	F91.3 Oppositional defiant disorder	
6C90.0Z Oppositional defiant disorder with chronic irritability-anger, unspecified	F91.3 Oppositional defiant disorder	
6C90.1 Oppositional defiant disorder without chronic irritability-anger	F91.3 Oppositional defiant disorder	
C90.10 Oppositional defiant disorder without chronic irritability-anger with limited prosocial emotions	F91.3 Oppositional defiant disorder	

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6C90.11 Oppositional defiant disorder without chronic irritability-anger with typical prosocial emotions	F91.3 Oppositional defiant disorder	
6C90.1Z Oppositional defiant disorder without chronic irritability-anger, unspecified	F91.3 Oppositional defiant disorder	
6C90.Z Oppositional defiant disorder, unspecified	F91.3 Oppositional defiant disorder	
6C91 Conduct-dissocial disorder	F91 Conduct disorders 4-character code: F91.9 Conduct disorder, unspecified	
6C91.0 Conduct-dissocial disorder, childhood onset	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.00 Conduct-dissocial disorder, childhood onset with limited prosocial emotions	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.01 Conduct-dissocial disorder, childhood onset with typical prosocial emotions	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.0Z Conduct-dissocial disorder, childhood onset, unspecified	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.1 Conduct-dissocial disorder, adolescent onset	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.10 Conduct-dissocial disorder, adolescent onset with limited prosocial emotions	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.11 Conduct-dissocial disorder, adolescent onset with typical prosocial emotions	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.1Z Conduct-dissocial disorder, adolescent onset, unspecified	F91 Conduct disorders 4-character code: F91.8 Other conduct disorders	
6C91.Z Conduct-dissocial disorder, unspecified	F91.9 Conduct disorder, unspecified	
6C9Y Other specified disruptive behaviour or dissocial disorder	F91.8 Other conduct disorders	

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6C9Z Disruptive behaviour or dissocial disorder, unspecified	F91.9 Conduct disorder, unspecified	
Personality disorders and related traits		This ICD-11 grouping first requires the diagnosis and severity of a personality disorder using the following categories: • 6D10.0 Mild personality disorder • 6D10.1 Moderate personality disorder • 6D10.2 Severe personality disorder • 6D10.Z Personality disorder, severity unspecified. The 6D10.*x* category above can then be described by indicating the presence of one or more of the following trait domains included in 6D11 Prominent personality traits or patterns: • 6D11.0 Negative affectivity in personality disorder or personality difficulty • 6D11.1 Detachment in personality disorder or personality difficulty • 6D11.2 Dissociality in personality disorder or personality difficulty • 6D11.3 Disinhibition in personality disorder or personality difficulty • 6D11.4 Anankastia in personality disorder or personality difficulty • 6D11.5 Borderline pattern.

ICD-11	ICD-10	Notes
6D10 Personality disorder	F60 Specific Personality Disorders 4-character code: F60.9 Personality disorder, unspecified	
6D10.0 Mild personality disorder	F60.9 Personality disorder, unspecified	Use if categories from 6D11 Prominent personality traits or patterns are not available.
6D10.1 Moderate personality disorder	F60.9 Personality disorder, unspecified	Use if categories from 6D11 Prominent personality traits or patterns are not available.
6D10.2 Severe personality disorder	F60.9 Personality disorder, unspecified	Use if categories from 6D11 Prominent personality traits or patterns are not available.
6D10.Z Personality disorder, severity unspecified	F60.9 Personality disorder, unspecified	Use if categories from 6D11 Prominent personality traits or patterns are not available.
6D10.*x* AND 6D11.0 Negative affectivity 6D11.1 Detachment 6D11.2 Dissociality (6D10.*x*/6D11.0/6D11.1/6D11.2)	F60.0 Paranoid personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.1 Detachment (6D10.*x*/6D11.1)	F60.1 Schizoid personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.2 Dissociality 6D11.3 Disinhibition (6D10.*x*/6D11.2/6D11.3)	F60.2 Dissocial personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.

ICD-11	ICD-10	Notes
6D10.*x* AND 6D11.0 Negative affectivity 6D11.3 Disinhibition (6D10.*x*/6D11.0/6D11.3) OR 6D10.*x* AND 6D11.5 Borderline pattern, with or without any other combination of prominent personality traits or patterns (6D10.*x*/6D11.5/...)	F60.31 Emotionally unstable personality disorder, borderline type 4-character code: F60.3 Emotionally unstable personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.0 Negative affectivity 6D11.2 Dissociality 6D11.3 Disinhibition ((6D10.*x*/6D11.0/6D11.2/6D11.3)	F60.4 Histrionic personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.0 Negative affectivity 6D11.4 Anankastia (6D10.*x*/6D11.0/6D11.4)	F60.5 Anankastic personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.0 Negative affectivity 6D11.1 Detachment (6D10.*x*/6D11.0/6D11.1)	F60.6 Anxious [avoidant] personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
6D10.*x* AND 6D11.0 Negative affectivity (6D10.*x*/6D11.0)	F60.7 Dependent personality disorder	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.

ICD-11	ICD-10	Notes
6D10.*x* AND any combination of prominent personality traits or patterns not listed above	F60.8 Other specific personality disorders	The x in the left column is a placeholder for the digit indicating the severity level of the personality disorder: • 0 = Mild • 1 = Moderate • 2 = Severe • Z = Severity unspecified.
Paraphilic disorders		
6D30 Exhibitionistic disorder	F65.2 Exhibitionism	
6D31 Voyeuristic disorder	F65.3 Voyeurism	
6D32 Paedophilic disorder	F65.4 Paedophilia	
6D33 Coercive sexual sadism disorder	F65.8 Other disorders of sexual preference	
6D34 Frotteuristic disorder	F65.8 Other disorders of sexual preference	
6D35 Other paraphilic disorder involving non-consenting individuals	F65.8 Other disorders of sexual preference	
6D36 Paraphilic disorder involving solitary behaviour or consenting individuals	F65.8 Other disorders of sexual preference	
6D3Z Paraphilic disorder, unspecified	F65.9 Disorder of sexual preference, unspecified	
Factitious disorders		
6D50 Factitious disorder imposed on self	F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]	
6D51 Factitious disorder imposed on another	F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]	
6D5Z Factitious disorder, unspecified	F68.1 Intentional production or feigning of symptoms or disabilities, either physical or psychological [factitious disorder]	
Neurocognitive disorders		
6D70 Delirium	Etiology must be specified (see below).	
6D70.0 Delirium due to disease classified elsewhere	F05 Delirium, not induced by alcohol and other psychoactive substances 4-character code: F05.8 Other delirium	

ICD-11	ICD-10	Notes
6D70.1 Delirium due to psychoactive substances, including medications	F1x.03 Mental and behavioural disorders due to psychoactive substance use: acute intoxication with delirium 4-character code: F1x.0 Mental and behavioural disorders due to psychoactive substance use: acute intoxication OR F1x.4 Mental and behavioural disorders due to psychoactive substance use: withdrawal state with delirium OR F1x.8 Mental and behavioural disorders due to psychoactive substance use: other mental and behavioural disorders	The x in the middle column is a placeholder for the digit indicating the substance class in ICD-10: • 0 = alcohol • 1 = opioids • 2 = cannabinoids • 3 = sedatives or hypnotics • 4 = cocaine • 5 = stimulants, including caffeine • 6 = hallucinogens • 7 = tobacco • 8 = volatile solvents • 9 = multiple or other psychoactive substances. Use F1x.8 if intoxication/ withdrawal status is unknown.
6D70.2 Delirium due to multiple etiological factors	F05 Delirium, not induced by alcohol and other psychoactive substances 4-character code: F05.8 Other delirium OR F19.4 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances withdrawal state with delirium	Use F05 or F05.8 unless multiple etiological factors refer entirely to multiple psychoactive substances, in which case F19.4 should be used.
6D70.Y Delirium, other specified cause	F05.8 Other delirium	
6D70.Z Delirium, unknown or unspecified cause	F05.9 Delirium, unspecified	
6D71 Mild neurocognitive disorder	F06.7 Mild cognitive disorder	
6D72 Amnestic disorder	Etiology must be specified (see below).	
6D72.0 Amnestic disorder due to diseases classified elsewhere	F04 Organic amnesic syndrome, not induced by alcohol and other psychoactive substances No 4-character code available	
6D72.1 Amnestic disorder due to psychoactive substances, including medications	Substance must be specified (see below).	
6D72.10 Amnestic disorder due to use of alcohol	F10.6 Mental and behavioural disorders due to use of alcohol: amnesic syndrome	
6D72.11 Amnestic disorder due to use of sedatives, hypnotics or anxiolytics	F13.6 Mental and behavioural disorders due to use of sedatives or hypnotics: amnesic syndrome	
6D72.12 Amnestic disorder due to other specified psychoactive substance, including medications	F19.6 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: amnesic syndrome	
6D72.13 Amnestic disorder due to use of volatile inhalants	F18.6 Mental and behavioural disorders due to use of volatile solvents: amnesic syndrome	

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6D72.Y Amnestic disorder, other specified cause	F04 Organic amnesic syndrome, not induced by alcohol and other psychoactive substances No 4-character code available	
6D72.Z Amnestic disorder, unknown or unspecified cause	F04 Organic amnesic syndrome, not induced by alcohol and other psychoactive substances No 4-character code available OR F19.6 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substance uses: amnesic syndrome	If insufficient information is available to make a general etiological determination, use F04.
Dementia	**Etiology must be specified (see below).**	
6D80 Dementia due to Alzheimer disease	F00 Dementia in Alzheimer disease 4-character code: F00.9 Dementia in Alzheimer disease, unspecified	
6D80.0 Dementia due to Alzheimer disease with early onset	F00.0 Dementia in Alzheimer disease with early onset	
6D80.1 Dementia due to Alzheimer disease with late onset	F00.1 Dementia in Alzheimer disease with late onset	
6D80.2 Alzheimer disease dementia, mixed type, with cerebrovascular disease	F00.2 Dementia in Alzheimer disease, atypical or mixed type	
6D80.3 Alzheimer disease dementia, mixed type, with other nonvascular etiologies	F00.2 Dementia in Alzheimer disease, atypical or mixed type	
6D80.Z Dementia due to Alzheimer disease, onset unknown or unspecified	F00.9 Dementia in Alzheimer disease, unspecified	
6D81 Dementia due to cerebrovascular disease	F01 Vascular dementia 4-character code: F01.9 Vascular dementia, unspecified	
6D82 Dementia due to Lewy body disease	F02.8 Dementia in other diseases classified elsewhere	
6D83 Frontotemporal dementia	F02 Dementia in other diseases classified elsewhere No 4-character code available OR F02.0 Dementia in Pick disease	
6D84 Dementia due to psychoactive substances, including medications	Substance must be specified (see below).	

ICD-11	ICD-10	Notes
6D84.0 Dementia due to use of alcohol	F10.73 Mental and behavioural disorders due to use of alcohol: residual and late-onset psychotic disorder, dementia 4-character code: F10.7 Mental and behavioural disorders due to use of alcohol: residual and late-onset psychotic disorder	
6D84.1 Dementia due to use of sedatives, hypnotics or anxiolytics	F13.73 Mental and behavioural disorders due to use of sedatives or hypnotics: residual and late-onset psychotic disorder, dementia 4-character code: F13.7 Mental and behavioural disorders due to use of sedatives or hypnotics: residual and late-onset psychotic disorder	
6D84.2 Dementia due to use of volatile inhalants	F18.73 Mental and behavioural disorders due to use of volatile solvents: residual and late-onset psychotic disorder, dementia 4-character code: F18.7 Mental and behavioural disorders due to use of volatile solvents: residual and late-onset psychotic disorder	
6D84.Y Dementia due to other specified psychoactive substance	F19.73 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: residual and late-onset psychotic disorder, dementia 4-character code: F19.7 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances: residual and late-onset psychotic disorder	
6D85 Dementia due to diseases classified elsewhere	F02 Dementia in other diseases classified elsewhere No 4-character code available	
6D85.0 Dementia due to Parkinson disease	F02.3 Dementia in Parkinson disease	
6D85.1 Dementia due to Huntington disease	F02.2 Dementia in Huntington disease	
6D85.2 Dementia due to exposure to heavy metals and other toxins	F02.8 Dementia in other diseases classified elsewhere	
6D85.3 Dementia due to HIV	F02.4 Dementia in human immunodeficiency virus [HIV] disease	
6D85.4 Dementia due to multiple sclerosis	F02.8 Dementia in other diseases classified elsewhere	
6D85.5 Dementia due to prion disease	F02.1 Dementia in Creutzfeldt-Jakob disease OR F02.8 Dementia in other specified diseases classified elsewhere	
6D85.6 Dementia due to normal-pressure hydrocephalus	F02.8 Dementia in other diseases classified elsewhere	
6D85.7 Dementia due to injury to the head	F02.8 Dementia in other diseases classified elsewhere	
6D85.8 Dementia due to pellagra	F02.8 Dementia in other diseases classified elsewhere	
6D85.9 Dementia due to Down syndrome	F02.8 Dementia in other diseases classified elsewhere	
6D85.Y Dementia due to other specified disease classified elsewhere	F02.8 Dementia in other diseases classified elsewhere	
6D8Y Dementia, other specified cause	F02.8 Dementia in other specified diseases classified elsewhere	

ICD-11	ICD-10	Notes
6D8Z Dementia, unknown or unspecified cause	F03 Unspecified dementia No 4-character code available	
Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium		
6E20 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, without psychotic symptoms	O99.3 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium	
6E21 Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, with psychotic symptoms	O99.3 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium	
6E2Z Mental and behavioural disorders associated with pregnancy, childbirth or the puerperium, unspecified	O99.3 Mental disorders and diseases of the nervous system complicating pregnancy, childbirth and the puerperium	
Psychological or behavioural factors affecting disorders or diseases classified elsewhere		
6E40 Psychological or behavioural factors affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.0 Mental disorder affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.1 Psychological symptoms affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.2 Personality traits or coping style affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.3 Maladaptive health behaviours affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.4 Stress-related physiological response affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
6E40.Y Other specified psychological or behavioural factor affecting disorders and diseases classified elsewhere	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	

ICD-11	ICD-10	Notes
6E40.Z Psychological or behavioural factor affecting disorders and diseases classified elsewhere, unspecified	F54 Psychological and behavioural factors associated with disorders or diseases classified elsewhere No 4-character code available	
Secondary mental or behavioural syndromes associated with disorders and diseases classified elsewhere		
6E60 Secondary neurodevelopmental syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E60.0 Secondary speech or language syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E60.Y Other specified secondary neurodevelopmental syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E60.Z Secondary neurodevelopmental syndrome, unspecified	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E61 Secondary psychotic syndrome	F06.0 Organic hallucinosis OR F06.2 Organic delusional [schizophrenia-like] disorder	Select F06.0 or F06.2 based on whether hallucinations or delusions predominate, although both may occur in either category.
6E61.0 Secondary psychotic syndrome with hallucinations	F06.0 Organic hallucinosis	
6E61.1 Secondary psychotic syndrome with delusions	F06.2 Organic delusional [schizophrenia-like] disorder	
6E61.2 Secondary psychotic syndrome with hallucinations and delusions	F06.2 Organic delusional [schizophrenia-like] disorder	
6E61.3 Secondary psychotic syndrome with unspecified symptoms	F09 Unspecified organic or symptomatic mental disorder	
6E62 Secondary mood syndrome	F06.3 Organic mood [affective] disorders	
6E62.0 Secondary mood syndrome with depressive symptoms	F06.32 Organic depressive disorder 4-character code: F06.3 Organic mood [affective] disorders	
6E62.1 Secondary mood syndrome with manic symptoms	F06.30 Organic manic disorder 4-character code: F06.3 Organic mood [affective] disorders	
6E62.2 Secondary mood syndrome with mixed symptoms	F06.33 Organic mixed affective disorder 4-character code: F06.3 Organic mood [affective] disorders	
6E62.3 Secondary mood syndrome with unspecified symptoms	F06.3 Organic mood [affective] disorders	
6E63 Secondary anxiety syndrome	F06.4 Organic anxiety disorder	
6E64 Secondary obsessive-compulsive or related syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E65 Secondary dissociative syndrome	F06.5 Organic dissociative disorder	
6E66 Secondary impulse control syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E67 Secondary neurocognitive syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E68 Secondary personality change	F07.0 Organic personality disorder	
6E69 Secondary catatonia syndrome	F06.1 Organic catatonic disorder	
6E6Y Other specified secondary mental or behavioural syndrome	F06.8 Other specified mental disorders due to brain damage and dysfunction and to physical disease	
6E6Z Secondary mental or behavioural syndrome, unspecified	F06.9 Unspecified mental disorder due to brain damage and dysfunction and to physical disease	

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Clinic-based study on behavioural indicators for disorders of intellectual development

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Clinic-based study on obsessive-compulsive and related disorders

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Disorders due to substance use or addictive behaviours

International field testing

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