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**DSM-5-TR™**

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AMERICAN PSYCHIATRIC ASSOCIATION

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## Preface to DSM-5-TR

**The American Psychiatric Association's** *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Text Revision (DSM-5-TR), is the first published revision to DSM-5. This revised manual integrates the original published DSM-5 diagnostic criteria with modifications (mostly for clarity) for over 70 disorders, comprehensively updated descriptive text accompanying each of the DSM disorders based on reviews of the literature since the publication of DSM-5, and the addition of a new diagnosis, prolonged grief disorder, and symptom codes for reporting suicidal and nonsuicidal self-injurious behavior. These changes differ from the scope of the prior text revision, DSM-IV-TR, in which the updates were confined almost exclusively to the text, leaving the diagnostic criteria virtually unchanged. This edition also integrates all prior online updates made to DSM-5 after its publication in 2013, in response to usage, specific scientific advances, and ICD-10-CM coding adjustments through an iterative revision process. Consequently, DSM-5-TR is the product of three separate revision processes, each one overseen by separate (but overlapping) groups of experts: the development of the original DSM-5 diagnostic criteria and text by the DSM-5 Task Force, published in 2013; updates to the DSM-5 diagnostic criteria and text by the DSM Steering Committee, which has overseen the iterative revision process; and fully updated text overseen by the Revision Subcommittee.

The clinical and research understanding of mental disorders continues to advance. As a result, most of the DSM-5-TR disorder texts have had at least some revision since the 9 years from original publication in DSM-5, with the overwhelming majority having had significant revisions. Sections of the text that were most extensively updated were Prevalence, Risk and Prognostic Factors, Culture-Related Diagnostic Issues, Sex- and Gender-Related Diagnostic Issues, Association With Suicidal Thoughts or Behavior, and Comorbidity. Also, for the first time ever, the entire DSM text has been reviewed and revised by a Work Group on Ethnoracial Equity and Inclusion to ensure appropriate attention to risk factors such as the experience of racism and discrimination, as well as to the use of non-stigmatizing language. For future periodic DSM-5-TR coding and other updates, see [www.dsm5.org](http://www.dsm5.org).

For benefit of reference in this manual, “DSM” refers generally to DSM as an entity, not specifying a particular edition (e.g., “Clinical training and experience are needed to use DSM for determining a clinical diagnosis.”). “DSM-5” refers to the entire set of currently approved criteria sets, disorders, other conditions, and content officially published in May 2013. “DSM-5-TR” refers to approved text in this current volume. Although the scope of the text revision did not include conceptual changes to the criteria sets or to other DSM-5 constructs, the need to make changes in certain diagnostic criteria sets for the purpose of clarification became apparent in conjunction with the text updates made across the book. Because the conceptual construct of criteria is unchanged, the criteria sets in DSM-5-TR that had their origins in DSM-5 are still referred to as “DSM-5-criteria.” The new diagnostic entity prolonged grief disorder is referred to

as a DSM-5-TR disorder, because of its addition in this volume.

The development of DSM-5-TR was a tremendous team effort. We are especially indebted to the tireless efforts of Wilson M. Compton, M.D., M.P.E., and Daniel S. Pine, M.D., as DSM-5 Text Revision Subcommittee Vice Chairs, as well as the more than 200 experts from across our field who did the lion's share of the work in the preparation of the text revision. We would also like to thank Paul Appelbaum, M.D., Chair of the DSM Steering

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Committee, along with the entire DSM Steering Committee, for their careful review of the text and criteria clarifications, and for making other helpful suggestions. Special gratitude goes to Ann M. Eng, DSM Managing Editor, for her timely shepherding of the DSM-5-TR development process from planning to completion and for her meticulous attention to detail, all critical to the success of this revision. We are grateful for the valuable contributions and help of Nitin Gogtay, M.D., Chief of the American Psychiatric Association Division of Research and Deputy Medical Director; Diana E. Clarke, Ph.D., Managing Director of Research and Senior Research Statistician/Epidemiologist; and Lamyaa H. Yousif, M.D., Ph.D., M.Sc., Senior DSM Operations Manager and Research Associate. We are thankful for the leadership of John McDuffie, Publisher, American Psychiatric Association Publishing, and the work of the following editorial and production staff at American Psychiatric Association Publishing in bringing this important work to fruition: Greg Kuny, Managing Editor, Books; Tammy Cordova, Graphic Design Manager; Andrew Wilson, Director of Production; Judy Castagna, Assistant Director of Production Services; Erika Parker, Acquisitions Editor; Alisa Riccardi, Senior Editor, Books; and Carrie Y. Farnham, Senior Editor, Books. Finally, we also recognize with appreciation Saul Levin, M.D., M.P.A., CEO and Medical Director of the American Psychiatric Association, for his advocacy and support of this comprehensive text revision.

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## Preface to DSM-5

**The American Psychiatric Association's** *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2015) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and

may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorder will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.

- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the “dementias” or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

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specific molecular genetic findings for rare variants of Alzheimer’s disease and Huntington’s disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative “hybrid” model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online ([www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5)), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at [www.psychiatry.org/dsm5](http://www.psychiatry.org/dsm5).

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a

cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assembly

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review process. Special thanks go to Helena C. Kraemer, Ph.D., for her expert statistical consultation; Michael B. First, M.D., for his valuable input on the coding and review of criteria; and Paul S. Appelbaum, M.D., for feedback on forensic issues. Maria N. Ward, M.Ed., RHIT, CCS-P, also helped in verifying all ICD coding. The Summit Group, which included these consultants, the chairs of all review groups, the task force chairs, and the APA executive officers, chaired by Dilip V. Jeste, M.D., provided leadership and vision in helping to achieve compromise and consensus. This level of commitment has contributed to the balance and objectivity that we feel are hallmarks of DSM-5.

We especially wish to recognize the outstanding APA Division of Research staff—identified in the Task Force and Work Group listing at the front of this manual—who worked tirelessly to interact with the task force, work groups, advisors, and reviewers to resolve issues, serve as liaisons between the groups, direct and manage the academic and routine clinical practice field trials, and record decisions in this important process. In particular, we appreciate the support and guidance provided by James H. Scully Jr., M.D., Medical Director and CEO of the APA, through the years and travails of the development process. Finally, we thank the editorial and production staff of American Psychiatric Publishing—specifically, Rebecca Rinehart, Publisher; John McDuffie, Editorial Director; Ann Eng, Senior Editor; Greg Kuny, Managing Editor; and Tammy Cordova, Graphics Design Manager—for their guidance in bringing this all together and creating the final product. It is the culmination of efforts of many talented individuals who dedicated their time, expertise, and passion that made DSM-5 possible.

*David J. Kupfer, M.D.*  
DSM-5 Task Force Chair  
*Darrel A. Regier, M.D., M.P.H.*  
DSM-5 Task Force Vice-Chair  
December 19, 2012

## DSM-5-TR Classification

Before each disorder name, ICD-10-CM codes are provided. Blank lines indicate that the ICD-10-CM code depends on the applicable subtype, specifier, or class of substance. For periodic DSM-5-TR coding and other updates, see [www.dsm5.org](http://www.dsm5.org).

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

**Note for all mental disorders due to another medical condition:** Insert the name of the etiological medical condition within the name of the mental disorder due to [the medical condition]. The code and name for the etiological medical condition should be listed first immediately before the mental disorder due to the medical condition.

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### Neurodevelopmental Disorders (35)

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#### Intellectual Developmental Disorders (37)

_____	Intellectual Developmental Disorder (Intellectual Disability) (37) <i>Specify</i> current severity:
<b>F70</b>	Mild
<b>F71</b>	Moderate
<b>F72</b>	Severe
<b>F73</b>	Profound
<b>F88</b>	Global Developmental Delay (46)
<b>F79</b>	Unspecified Intellectual Developmental Disorder (Intellectual Disability) (46)

#### Communication Disorders (46)

<b>F80.2</b>	Language Disorder (47)
<b>F80.0</b>	Speech Sound Disorder (50)
<b>F80.81</b>	Childhood-Onset Fluency Disorder (Stuttering) (51) <b>Note:</b> Later-onset cases are diagnosed as F98.5 adult-onset fluency disorder.
<b>F80.82</b>	Social (Pragmatic) Communication Disorder (54)
<b>F80.9</b>	Unspecified Communication Disorder (56)

#### Autism Spectrum Disorder (56)

**F84.0** Autism Spectrum Disorder (56)  
*Specify* current severity: Requiring very substantial support, Requiring substantial support, Requiring support  
*Specify* if: With or without accompanying intellectual impairment, With or without accompanying language impairment  
*Specify* if: Associated with a known genetic or other medical condition or environmental factor  
(**Coding note:** Use additional code to identify the associated genetic or other medical condition);  
Associated with a neurodevelopmental, mental, or behavioral problem  
*Specify* if: With catatonia (use additional code F06.1)

### **Attention-Deficit/Hyperactivity Disorder (68)**

\_\_\_\_ Attention-Deficit/Hyperactivity Disorder (68)  
*Specify* if: In partial remission  
*Specify* current severity: Mild, Moderate, Severe  
*Specify* whether:

**F90.2** Combined presentation

**F90.0** Predominantly inattentive presentation

**F90.1** Predominantly hyperactive/impulsive presentation

**F90.8** Other Specified Attention-Deficit/Hyperactivity Disorder (76)

**F90.9** Unspecified Attention-Deficit/Hyperactivity Disorder (76)

### **Specific Learning Disorder (76)**

\_\_\_\_ Specific Learning Disorder (76)  
*Specify* current severity: Mild, Moderate, Severe  
*Specify* if:

**F81.0** With impairment in reading (specify if with word reading accuracy, reading rate or fluency, reading comprehension)

**F81.81** With impairment in written expression (specify if with spelling accuracy, grammar and punctuation accuracy, clarity or organization of written expression)

**F81.2** With impairment in mathematics (specify if with number sense, memorization of arithmetic facts, accurate or fluent calculation, accurate math reasoning)

### **Motor Disorders (85)**

**F82** Developmental Coordination Disorder (85)

**F98.4** Stereotypic Movement Disorder (89)  
*Specify* if: With self-injurious behavior, Without self-injurious behavior  
*Specify* if: Associated with a known genetic or other medical condition, neurodevelopmental disorder, or environmental factor  
*Specify* current severity: Mild, Moderate, Severe

### **Tic Disorders**

**F95.2** Tourette's Disorder (93)

**F95.1** Persistent (Chronic) Motor or Vocal Tic Disorder (93)  
*Specify* if: With motor tics only, With vocal tics only

- F95.0**                      Provisional Tic Disorder (93)
- F95.8**                      Other Specified Tic Disorder (98)
- F95.9**                      Unspecified Tic Disorder (98)
- Other Neurodevelopmental Disorders (99)**
- F88**                         Other Specified Neurodevelopmental Disorder (99)
- F89**                         Unspecified Neurodevelopmental Disorder (99)

## Schizophrenia Spectrum and Other Psychotic Disorders (101)

The following specifiers apply to Schizophrenia Spectrum and Other Psychotic Disorders where indicated:

<sup>a</sup>*Specify* if: The following course specifiers are only to be used after a 1-year duration of the disorder: First episode, currently in acute episode; First episode, currently in partial remission; First episode, currently in full remission; Multiple episodes, currently in acute episode; Multiple episodes, currently in partial remission; Multiple episodes, currently in full remission; Continuous; Unspecified

<sup>b</sup>*Specify* if: With catatonia (use additional code F06.1)

<sup>c</sup>*Specify* current severity of delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression, and mania symptoms

- F21**                         Schizotypal (Personality) Disorder (104)
- F22**                         Delusional Disorder<sup>a,c</sup> (104)  
*Specify* whether: Erotomanic type, Grandiose type, Jealous type, Persecutory type, Somatic type, Mixed type, Unspecified type  
*Specify* if: With bizarre content
- F23**                         Brief Psychotic Disorder<sup>b,c</sup> (108)  
*Specify* if: With marked stressor(s), Without marked stressor(s), With peripartum onset
- F20.81**                      Schizophreniform Disorder<sup>b,c</sup> (111)  
*Specify* if: With good prognostic features, Without good prognostic features
- F20.9**                      Schizophrenia<sup>a,b,c</sup> (113)
- \_\_\_\_\_  
                                  Schizoaffective Disorder<sup>a,b,c</sup> (121)  
*Specify* whether:
- F25.0**                      Bipolar type
- F25.1**                      Depressive type
- \_\_\_\_\_  
                                  Substance/Medication-Induced Psychotic Disorder<sup>c</sup> (126)  
**Note:** For applicable ICD-10-CM codes, refer to the substance classes under Substance-Related and Addictive Disorders for the specific substance/medication-induced psychotic disorder. See also the criteria set and corresponding recording procedures in the manual for more information.  
**Coding note:** The ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given.  
*Specify* if: With onset during intoxication, With onset during withdrawal, With onset after medication use

_____	Psychotic Disorder Due to Another Medical Condition <sup>c</sup> (131) <i>Specify</i> whether:
<b>F06.2</b>	With delusions
<b>F06.0</b>	With hallucinations
<b>F06.1</b>	Catatonia Associated With Another Mental Disorder (Catatonia Specifier) (135)
<b>F06.1</b>	Catatonic Disorder Due to Another Medical Condition (136)
<b>F06.1</b>	Unspecified Catatonia (137) <b>Note:</b> Code first <b>R29.818</b> other symptoms involving nervous and musculoskeletal systems.
<b>F28</b>	Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (138)
<b>F29</b>	Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (138)

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## Bipolar and Related Disorders (139)

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

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

<sup>b</sup>*Specify:* With anxious distress (*specify* current severity: mild, moderate, moderate-severe, severe); With mixed features; With rapid cycling; With peripartum onset; With seasonal pattern

_____	Bipolar I Disorder <sup>a</sup> (139)
_____	Current or most recent episode manic
<b>F31.11</b>	Mild
<b>F31.12</b>	Moderate
<b>F31.13</b>	Severe
<b>F31.2</b>	With psychotic features
<b>F31.73</b>	In partial remission
<b>F31.74</b>	In full remission
<b>F31.9</b>	Unspecified
<b>F31.0</b>	Current or most recent episode hypomanic
<b>F31.71</b>	In partial remission
<b>F31.72</b>	In full remission
<b>F31.9</b>	Unspecified
_____	Current or most recent episode depressed
<b>F31.31</b>	Mild
<b>F31.32</b>	Moderate
<b>F31.4</b>	Severe

<b>F31.5</b>	With psychotic features
<b>F31.75</b>	In partial remission
<b>F31.76</b>	In full remission
<b>F31.9</b>	Unspecified
<b>F31.9</b>	Current or most recent episode unspecified

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<b>F31.81</b>	Bipolar II Disorder (150) <i>Specify</i> current or most recent episode: Hypomanic <sup>b</sup> , Depressed <sup>a</sup> <i>Specify</i> course if full criteria for a mood episode are not currently met: In partial remission, In full remission <i>Specify</i> severity if full criteria for a major depressive episode are currently met: Mild, Moderate, Severe
<b>F34.0</b>	Cyclothymic Disorder (159) <i>Specify</i> if: With anxious distress ( <i>specify</i> current severity: mild, moderate, moderate-severe, severe) Substance/Medication-Induced Bipolar and Related Disorder (162) <b>Note:</b> For applicable ICD-10-CM codes, refer to the substance classes under Substance-Related and Addictive Disorders for the specific substance/medication-induced bipolar and related disorder. See also the criteria set and corresponding recording procedures in the manual for more information. <b>Coding note:</b> The ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given. <i>Specify</i> if: With onset during intoxication, With onset during withdrawal, With onset after medication use
_____	Bipolar and Related Disorder Due to Another Medical Condition (166) <i>Specify</i> if:
<b>F06.33</b>	With manic features
<b>F06.33</b>	With manic- or hypomanic-like episode
<b>F06.34</b>	With mixed features
<b>F31.89</b>	Other Specified Bipolar and Related Disorder (168)
<b>F31.9</b>	Unspecified Bipolar and Related Disorder (169)
<b>F39</b>	Unspecified Mood Disorder (169)

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## Depressive Disorders (177)

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<b>F34.81</b>	Disruptive Mood Dysregulation Disorder (178)
_____	Major Depressive Disorder (183) <i>Specify:</i> With anxious distress ( <i>specify</i> current severity: mild, moderate, moderate-severe, severe); With mixed features; With melancholic features; With atypical features; With mood-congruent psychotic features; With mood-incongruent psychotic features; With catatonia (use additional code F06.1); With peripartum onset; With seasonal pattern
_____	Single episode

<b>F32.0</b>	Mild
<b>F32.1</b>	Moderate
<b>F32.2</b>	Severe
<b>F32.3</b>	With psychotic features
<b>F32.4</b>	In partial remission
<b>F32.5</b>	In full remission
<b>F32.9</b>	Unspecified

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\_\_\_\_\_.\_\_\_\_ Recurrent episode

<b>F33.0</b>	Mild
<b>F33.1</b>	Moderate
<b>F33.2</b>	Severe
<b>F33.3</b>	With psychotic features
<b>F33.41</b>	In partial remission
<b>F33.42</b>	In full remission
<b>F33.9</b>	Unspecified

**F34.1** Persistent Depressive Disorder (193)

*Specify:* With anxious distress (*specify* current severity: mild, moderate, moderate-severe, severe);  
With atypical features

*Specify if:* In partial remission, In full remission

*Specify if:* Early onset, Late onset

*Specify if:* With pure dysthymic syndrome; With persistent major depressive episode; With intermittent major depressive episodes, with current episode; With intermittent major depressive episodes, without current episode

*Specify* current severity: Mild, Moderate, Severe

**F32.81** Premenstrual Dysphoric Disorder (197)

\_\_\_\_\_.\_\_\_\_ Substance/Medication-Induced Depressive Disorder (201)

**Note:** For applicable ICD-10-CM codes, refer to the substance classes under Substance-Related and Addictive Disorders for the specific substance/medication-induced depressive disorder. See also the criteria set and corresponding recording procedures in the manual for more information.

**Coding note:** The ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given.

*Specify if:* With onset during intoxication, With onset during withdrawal, With onset after medication use

\_\_\_\_\_.\_\_\_\_ Depressive Disorder Due to Another Medical Condition (206)

*Specify if:*

<b>F06.31</b>	With depressive features
<b>F06.32</b>	With major depressive–like episode
<b>F06.34</b>	With mixed features

<b>F32.89</b>	Other Specified Depressive Disorder (209)
<b>F32.A</b>	Unspecified Depressive Disorder (210)
<b>F39</b>	Unspecified Mood Disorder (210)

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## Anxiety Disorders (215)

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<b>F93.0</b>	Separation Anxiety Disorder (217)
<b>F94.0</b>	Selective Mutism (222)
____.	Specific Phobia (224)
	<i>Specify if:</i>
<b>F40.218</b>	Animal
<b>F40.228</b>	Natural environment
____.	Blood-injection-injury

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<b>F40.230</b>	Fear of blood
<b>F40.231</b>	Fear of injections and transfusions
<b>F40.232</b>	Fear of other medical care
<b>F40.233</b>	Fear of injury
<b>F40.248</b>	Situational
<b>F40.298</b>	Other
<b>F40.10</b>	Social Anxiety Disorder (229)
	<i>Specify if:</i> Performance only
<b>F41.0</b>	Panic Disorder (235)
____.	Panic Attack Specifier (242)
<b>F40.00</b>	Agoraphobia (246)
<b>F41.1</b>	Generalized Anxiety Disorder (250)
____.	Substance/Medication-Induced Anxiety Disorder (255)
	<b>Note:</b> For applicable ICD-10-CM codes, refer to the substance classes under Substance-Related and Addictive Disorders for the specific substance/medication-induced anxiety disorder. See also the criteria set and corresponding recording procedures in the manual for more information.
	<b>Coding note:</b> The ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given.
	<i>Specify if:</i> With onset during intoxication, With onset during withdrawal, With onset after medication use
<b>F06.4</b>	Anxiety Disorder Due to Another Medical Condition (258)
<b>F41.8</b>	Other Specified Anxiety Disorder (261)

**F41.9** Unspecified Anxiety Disorder (261)

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## Obsessive-Compulsive and Related Disorders (263)

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The following specifier applies to Obsessive-Compulsive and Related Disorders where indicated:

<sup>a</sup>*Specify* if: With good or fair insight, With poor insight, With absent insight/delusional beliefs

**F42.2** Obsessive-Compulsive Disorder<sup>a</sup> (265)

*Specify* if: Tic-related

**F45.22** Body Dysmorphic Disorder<sup>a</sup> (271)

*Specify* if: With muscle dysmorphia

**F42.3** Hoarding Disorder<sup>a</sup> (277)

*Specify* if: With excessive acquisition

**F63.3** Trichotillomania (Hair-Pulling Disorder) (281)

**F42.4** Excoriation (Skin-Picking) Disorder (284)

\_\_\_\_\_. Substance/Medication-Induced Obsessive-Compulsive and Related Disorder (287)

**Note:** For applicable ICD-10-CM codes, refer to the substance classes under Substance-Related and Addictive Disorders for the specific substance/medication-induced obsessive-compulsive and related disorder. See also the criteria set and corresponding recording procedures in the manual for more information.

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**Coding note:** The ICD-10-CM code depends on whether or not there is a comorbid substance use disorder present for the same class of substance. In any case, an additional separate diagnosis of a substance use disorder is not given.

*Specify* if: With onset during intoxication, With onset during withdrawal, With onset after medication use

**F06.8** Obsessive-Compulsive and Related Disorder Due to Another Medical Condition (291)

*Specify* if: With obsessive-compulsive disorder–like symptoms, With appearance preoccupations, With hoarding symptoms, With hair-pulling symptoms, With skin-picking symptoms

**F42.8** Other Specified Obsessive-Compulsive and Related Disorder (293)

**F42.9** Unspecified Obsessive-Compulsive and Related Disorder (294)

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## Trauma- and Stressor-Related Disorders (295)

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**F94.1** Reactive Attachment Disorder (295)

*Specify* if: Persistent

*Specify* current severity: Severe

**F94.2** Disinhibited Social Engagement Disorder (298)

*Specify* if: Persistent

*Specify* current severity: Severe

**F43.10** Posttraumatic Stress Disorder (301)

*Specify* whether: With dissociative symptoms

*Specify* if: With delayed expression

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