The Authoritative Guide To Psychiatric Diagnosis

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THE AUTHORITATIVE GUIDE TO PSYCHIATRIC DIAGNOSIS

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Preface to Second Printing

The second printing of *The Authoritative Guide to Psychiatric Diagnosis* has been prompted by two factors. First was the development of two new mnemonics for Attention-Deficit/Hyperactive Disorder, DO I FIDGET?© and CAN'T FOCUS?© that are much more user friendly than the previous ADHD mnemonic, IMPULSIVE©. More important for the future of this book, is the interest expressed by several pharmaceutical companies to disseminate this book widely to physicians. I am especially pleased to have them take an interest in this book as they have consistently been in the forefront of new developments in psychiatry. Hopefully, as it reaches more of my colleagues, I will get additional feedback and suggestions so that *The Authoritative Guide to Psychiatric Diagnosis* can continue to grow and improve.

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Acknowledgments

I would like to thank my wife, Caryn, and my four children, Jamie, Mishy, Jake, and Zara who, throughout all times, put up with my rhymes and mnemonics. I would also like to thank my patients and colleagues for their feedback on these mnemonics. Finally, I would like to thank all of the companies in the pharmaceutical industry with whom I have been involved. Doing both research and teaching has provided the impetus to develop and to use these mnemonics in the advancement of the science of psychiatric diagnosis and treatment.

Enjoy the mnemonics. Hopefully, whether you are a physician, researcher, lawyer, mental health professional, patient, or student of life, they will help you to understand more clearly these psychiatric illnesses.

Contents

Introduction

I first began using mnemonics to remember the colors of the rainbow (ROY G. BIV) and then to remember the order of the planets from the sun (although now it's easier to remember the planets themselves than the mnemonic). During my elementary school years, my father mentioned his mnemonic, PRACS NELO AEFC. Beginning in 1948, it was the way that he remembered as a newlywed the street names on the Lower East Side of Manhattan from Pitt to Christie. In the eighth grade while studying for an Earth Science examination, I created a 50-lettered mnemonic to help me remember all the prehistoric eras, their associated dinosaurs, and their major characteristics. Although that mnemonic allowed me to get 100% on the examination, it has sadly long been forgotten.

Mnemonics have a time-honored position in medical education. They are taught from peer to peer. And in anatomy class, even on the first day of classes, they are handed down from one generation of students to the next. Intermittently, I have maintained this tradition throughout my 25 years as a physician. Most recently, while studying for my Added Qualifications as a Forensic Psychiatrist, I created and used them to master the details of the landmark legal cases that interface psychiatry and medicine with the law.

The more a mnemonic is used, the better it is remembered. As a psychiatrist who evaluates and treats hundreds of patients in the office every month, I use these mnemonics with my patients to explain their diagnoses and symptoms according to the diagnostic criteria in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR™) of the American Psychiatric Association.

As a researcher and scientist doing clinical trials for many pharmaceutical companies, I use the mnemonics that I have developed when I work with research patients to clarify diagnostic concerns, to rule out exclusionary diagnoses, and to help measure CGI (Clinical Global Impression), a determination of severity and of improvement for the diagnosis that is being studied.

As a Forensic Psychiatrist, I include the mnemonics in reports, in depositions, and in the court room to clarify and simplify diagnostic concerns to a reasonable degree of medical certainty as I educate attorneys, juries, and judges.

This is hopefully just the first edition of my book. In the future, I would like to include case studies that will bring additional information to the users of this guide. But for starters, the mnemonics and the accompanying DSM-IV-TR™ diagnostic criteria, which I thank the American Psychiatric Association for their permission to use, should be able to stand on their own. Together, they make this book *The Authoritative Guide to Psychiatric Diagnosis*.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

CAN'T FOCUS?©

ADHD INATTENTIVE SUBTYPE
6 OF THESE 9 SYMPTOMS REQUIRED FOR DIAGNOSIS

CARELESS MISTAKES ARE MADE
ATTENTION CANNOT BE SUSTAINED
NECESSARY THINGS ARE LOST
TROUBLE LISTENING TO OTHERS
FAILS TO FINISH WORK OR FOLLOW INSTRUCTIONS
ORGANIZING TASKS IS DIFFICULT
CONCENTRATION-REQUIRING TASKS ARE AVOIDED
USUAL AND DAILY ACTIVITIES ARE FORGOTTEN
SOUNDS, SIGHTS, AND SMELLS ARE DISTRACTING

DO I FIDGET?©

ADHD HYPERACTIVE/IMPULSIVE SUBTYPE
6 OF THESE 9 SYMPTOMS REQUIRED FOR DIAGNOSIS

DIFFICULTY AWAITING TURN
ON THE GO OR DRIVEN BY A MOTOR
INTERRUPTS OR INTRUDES
FIDGETS OR SQUIRMS IN SEAT
IMPULSIVELY BLURTS OUT ANSWERS
DIFFICULTY PLAYING QUIETLY
GETS OUT OF SEAT
EXCESSIVE RUNNING, CLIMBING, (OR RESTLESSNESS)
TALKS EXCESSIVELY

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Based on DSM-IV-TR™ Criteria for Attention-Deficit/Hyperactivity Disorder, Combined Type

314.01 Attention-Deficit/Hyperactivity Disorder, Combined Type

A. Both (1) and (2):

(1) six (or more) of the following symptoms of **inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities

(b) often has difficulty sustaining attention in tasks or play activities

(c) often does not seem to listen when spoken to directly

(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

(e) often has difficulty organizing tasks and activities

(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

(h) is often easily distracted by extraneous stimuli

(i) is often forgetful in daily activities

(2) six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat

(b) often leaves seat in classroom or in other situations in which remaining seated is expected

(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)

(d) often has difficulty playing or engaging in leisure activities quietly

(e) is often "on the go" or often acts as if "driven by a motor"

(f) often talks excessively

Impulsivity

(g) often blurts out answers before questions have been completed

(h) often has difficulty awaiting turn

(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

ALZHEIMER'S DISEASE

DIM LIFE©

DEVELOPMENT OF MULTIPLE COGNITIVE DEFICITS MANIFESTED BY BOTH

IMPAIRED MEMORY (DIFFICULTY LEARNING NEW INFORMATION OR RECALLING PREVIOUSLY LEARNED INFORMATION) AND

MUST HAVE ONE (OR MORE) OF THE FOLLOWING COGNITIVE DISTURBANCES:

LANGUAGE DISTURBANCE WITH DIFFICULTY PRODUCING NAMES OF INDIVIDUALS AND OBJECTS (APHASIA);

IMPAIRED ABILITY TO CARRY OUT MOTOR ACTIVITIES DESPITE INTACT MOTOR FUNCTION (APRAXIA);

FAILURE TO RECOGNIZE OR IDENTIFY OBJECTS DESPITE INTACT SENSORY FUNCTION (AGNOSIA);

EXECUTIVE FUNCTIONING (I.E., ABILITY TO PLAN, INITIATE, STOP, SEQUENCE, MONITOR, ORGANIZE, ABSTRACT, ETC.) IS IMPAIRED.

294.1x Dementia of the Alzheimer's Type

A. The development of multiple cognitive deficits manifested by both

(1) memory impairment (impaired ability to learn new information or to recall previously learned information)

(2) one (or more) of the following cognitive disturbances:

(a) aphasia (language disturbance)

(b) apraxia (impaired ability to carry out motor activities despite intact motor function)

(c) agnosia (failure to recognize or identify objects despite intact sensory function)

(d) disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)

B. The cognitive deficits in Criteria A1 and A2 each cause significant impairment in social or occupational functioning and represent a significant decline from a previous level of functioning.

C. The course is characterized by gradual onset and continuing cognitive decline.

D. The cognitive deficits in Criteria A1 and A2 are not due to any of the following:

(1) other central nervous system conditions that cause progressive deficits in memory and cognition (e.g., cerebrovascular disease, Parkinson's disease, Huntington's disease, subdural hematoma, normal-pressure hydrocephalus, brain tumor)

(2) systemic conditions that are known to cause dementia (e.g., hypothyroidism, vitamin B_{12} or folic acid deficiency, niacin deficiency, hypercalcemia, neurosyphilis, HIV infection)

(3) substance-induced conditions

E. The deficits do not occur exclusively during the course of a delirium.

F. The disturbance is not better accounted for by another Axis I disorder (e.g., Major Depressive Disorder, Schizophrenia).

294.10 Without Behavioral Disturbance: if the cognitive disturbance is not accompanied by any clinically significant behavioral disturbance.

294.11 With Behavioral Disturbance: if the cognitive disturbance is accompanied by a clinically significant behavioral disturbance (e.g., wandering, agitation).

Specify: **With Early Onset:** if age 65 yrs. or less. **With Late Onset:** if over 65.

SUBSTANCE ABUSE

A pattern of substance use that

FAILS©

FAILURE TO FULFILL MAJOR ROLE OBLIGATIONS AT WORK, SCHOOL, OR HOME BECAUSE OF REPEATED SUBSTANCE USE.

AUTOMOBILE DRIVING OR OPERATING A MACHINE IN PHYSICALLY HAZARDOUS SITUATIONS WHEN IMPAIRED.

INTERPERSONAL OR SOCIAL PROBLEMS RECURRENTLY CAUSED OR WORSENED BY THE EFFECTS OF A SUBSTANCE.

LEGAL PROBLEMS RESULT FROM SUBSTANCE-RELATED BEHAVIORS. (E.G., DISORDERLY CONDUCT, ASSAULT AND BATTERY)

SIGNIFICANT IMPAIRMENT FROM ONE (OR MORE) OF THE ABOVE, & DEPENDENCE CRITERIA NEVER MET FOR THIS CLASS OF SUBSTANCE.

305.x0 Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(2) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)

(3) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance.

305.00 Alcohol Abuse
305.20 Cannabis Abuse
305.30 Hallucinogen Abuse
305.40 Sedative, Hypnotic, or Anxiolytic Abuse
305.50 Opioid Abuse
305.60 Cocaine Abuse
305.70 Amphetamine Abuse
305.90 Inhalant Abuse
305.90 Other (or Unknown) Substance Abuse
305.90 Phencyclidine Abuse

SUBSTANCE DEPENDENCE
I DRANK MORE©

I NTOXICATION OR DESIRED EFFECT NEEDS MARKEDLY INCREASED AMOUNTS OF THIS SUBSTANCE OR

D IMINISHED EFFECT OCCURS WITH CONTINUED USE OF THE SAME AMOUNT OF THE SUBSTANCE.

R ELIEF FROM OR AVOIDANCE OF WITHDRAWAL SYMPTOMS REQUIRES USE OF THIS (OR CLOSELY RELATED) SUBSTANCE OR

A AND B CRITERIA IN DSM-IV-TR™ MET FOR THE CHARACTERISTIC WITHDRAWAL SYNDROME FROM THIS SUBSTANCE.

N O SUCCESS IN EFFORTS TO CUT DOWN OR CONTROL SUBSTANCE USE, OR THERE IS A PERSISTENT DESIRE TO DO SO.

K NOWLEDGE THAT SUBSTANCE USE WORSENS PHYSICAL OR PSYCHOLOGICAL PROBLEMS DOES NOT PREVENT USE.

M ORE OF THE SUBSTANCE OFTEN TAKEN OR USED OVER A LONGER PERIOD OF TIME THAN WAS INTENDED.

O CCUPATIONAL, RECREATIONAL, OR SOCIAL ACTIVITIES ARE GIVEN UP OR REDUCED BECAUSE OF SUBSTANCE USE.

R EQUIRES 3 OR MORE OF THE SYMPTOMS IN A 12-MONTH PERIOD (FIRST 2 [TOLERANCE] AND SECOND 2 [WITHDRAWAL] EACH COUNT AS 1).

E XCESSIVE TIME SPENT OBTAINING SUBSTANCE, USING SUBSTANCE, OR RECOVERING FROM ITS EFFECTS.

303.90-304.90, 305.1 Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:

(a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect

(b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:

(a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

303.90 Alcohol Dependence
304.00 Opioid Dependence
304.10 Sedative, Hypnotic, or Anxiolytic Dependence
304.20 Cocaine Dependence
304.30 Cannabis Dependence
304.40 Amphetamine Dependence
304.50 Hallucinogen Dependence
304.60 Inhalant Dependence
304.60 Phencyclidine Dependence
304.80 Polysubstance Dependence
304.90 Other/Unknown Dependence
305.1 Nicotine Dependence

DYSTHYMIA
DESPOND©

For more days than not for the past two years (one year in children)

DEPRESSED MOOD AND TWO OR MORE OF THE FOLLOWING:

ENERGY LOSS OR FATIGUE;

SELF-ESTEEM IS LOW;

POOR SLEEP (INSOMNIA OR HYPERSOMNIA);

OVEREATING OR POOR APPETITE;

NO HOPE (FEELINGS OF HOPELESSNESS);

DIFFICULTY MAKING DECISIONS OR POOR CONCENTRATION.

300.4 Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years.
Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating
(2) insomnia or hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if: **With Early Onset:** age 21 years or less. **With Late Onset:** over 21.
Specify if: **With Atypical Features.**

MAJOR DEPRESSIVE EPISODE
DISGUSTED©

(5 of the 9 symptoms are required, including 1 of the first 2)

DEPRESSED MOOD MOST OF THE DAY, MOST DAYS (FEELS SAD, EMPTY OR TEARFUL). NOTE: IN CHILDREN & TEENS, MOOD CAN BE IRRITABLE.

INTEREST OR PLEASURE IN ALMOST ALL ACTIVITIES IS MARKEDLY DIMINISHED MOST DAYS. (SUBJECTIVELY OR BY OBSERVATION)

SLEEP PROBLEMS NEARLY EVERY DAY (INSOMNIA OR HYPERSOMNIA).

GUILT, EXCESSIVE OR INAPPROPRIATE, OR FEELINGS OF WORTHLESSNESS NEARLY EVERY DAY (MAY BE DELUSIONAL).

UNUSUALLY QUICK OR SLOW MOVING (OBSERVABLE PSYCHOMOTOR AGITATION OR RETARDATION).

SUICIDAL THOUGHTS, PLAN, OR ATTEMPT OR RECURRENT THOUGHTS OF DEATH (NOT JUST FEAR OF DYING).

THINKING OR CONCENTRATION PROBLEM OR INDECISIVENESS NEARLY EVERY DAY (SUBJECTIVE OR OBJECTIVE).

ENERGY LOSS OR FATIGUE NEARLY EVERY DAY OR EFFICIENCY WITH WHICH TASKS ARE ACCOMPLISHED IS REDUCED.

DECREASED OR INCREASED APPETITE NEARLY EVERY DAY, OR WEIGHT CHANGE (5% IN A MONTH) WITHOUT TRYING.

Major Depressive Episode

296.20-296.36 Major Depressive Disorders

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

MANIC EPISODE

DR. MANIA©

A DISTINCT PERIOD OF ABNORMALLY AND PERSISTENTLY ELEVATED OR EXPANSIVE MOOD WITH 3 (OR MORE) OF THE FOLLOWING, OR PERSISTENTLY IRRITABLE MOOD WITH 4 (OR MORE) OF THE FOLLOWING:

DISTRACTIBILITY;

RACING THOUGHTS OR FLIGHT OF IDEAS;

MORE TALKATIVE THAN USUAL OR PRESSURED SPEECH;

AGITATED MOTION OR MORE GOAL-DIRECTED ACTIVITY;

NEED FOR SLEEP IS DECREASED;

INFLATED SELF-ESTEEM OR GRANDIOSITY;

ACTIVITY INVOLVEMENT EXCESSIVE IN PLEASURABLE ACTIVITIES THAT HAVE A HIGH POTENTIAL FOR PAINFUL CONSEQUENCES.

Manic Episode

296.00-296.06, 296.40-296.7 Bipolar I Disorders

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode.

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

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

Hypomanic Episode

296.40 Bipolar I Disorder, Most Recent Episode Hypomanic
296.89 Bipolar II Disorder

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

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

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

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder.

Mixed Episode

296.60-296.66 Bipolar I Disorders, Most Recent Episode Mixed

A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a one-week period.

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

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

301.13 Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet the criteria for a Major Depressive Episode. Note: In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance.

D. The symptoms in Criterion A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

PREMENSTRUAL DYSPHORIC DISORDER

TOUGH MENSES©

(5 of the 11 symptoms are required including 1 as specified*)

TENSION, ANXIETY, BEING "KEYED UP" OR "ON EDGE"*

OVERWHELMED OR OUT OF CONTROL FEELINGS

UNABLE TO SLEEP OR EXCESSIVE SLEEP

GAIN IN WEIGHT, "BLOATING," SWOLLEN BREASTS, OR PAINS

HOPELESSNESS, SELF-DEPRECATION, OR MARKED DEPRESSION*

MARKED ANGER, IRRITABILITY OR INTERPERSONAL CONFLICTS*

EASY FATIGABILITY, LETHARGY, OR MARKED LACK OF ENERGY

NO OR DECREASED INTEREST IN HER USUAL ACTIVITIES OF LIFE

SUBJECTIVE SENSE OF DIFFICULTY IN CONCENTRATING

EXCESSIVE EATING, CHANGE IN APPETITE, OR FOOD CRAVINGS

SUDDEN MOOD CHANGES: SAD, TEARFUL , REJECTION SENSITIVE*

Research Criteria for Premenstrual Dysphoric Disorder

A. In most menstrual cycles during the past year, five (or more) of the following symptoms were present for most of the time during the last week of the luteal phase, began to remit within a few days after the onset of the follicular phase, and were absent in the week postmenses, with at least one of the symptoms being either (1), (2), (3), or (4):

(1) markedly depressed mood, feelings of hopelessness, or self-deprecating thoughts

(2) marked anxiety, tension, feelings of being "keyed up," or "on edge"

(3) marked affective lability (e.g., feeling suddenly sad or tearful or increased sensitivity to rejection)

(4) persistent and marked anger or irritability or increased interpersonal conflicts

(5) decreased interest in usual activities (e.g., work, school, friends, hobbies)

(6) subjective sense of difficulty in concentrating

(7) lethargy, easy fatigability, or marked lack of energy

(8) marked change in appetite, overeating, or specific food cravings

(9) hypersomnia or insomnia

(10) a subjective sense of being overwhelmed or out of control

(11) other physical symptoms, such as breast tenderness or swelling, headaches, joint or muscle pain, a sensation of "bloating," weight gain

Note: In menstruating females, the luteal phase corresponds to the period between ovulation and the onset of menses, and the follicular phase begins with menses. In nonmenstruating females (e.g., those who have had a hysterectomy), the timing of luteal and follicular phases may require measurement of circulating reproductive hormones.

B. The disturbance markedly interferes with work or school or with usual social activities and relationships with others (e.g., avoidance of social activities, decreased productivity and efficiency at work or school).

C. The disturbance is not merely an exacerbation of the symptoms of another disorder, such as Major Depressive Disorder, Panic Disorder, Dysthymic Disorder, or a Personality Disorder (although it may be superimposed on any of these disorders).

D. Criteria A, B, and C must be confirmed by prospective daily ratings during at least two consecutive symptomatic cycles. (The diagnosis may be made provisionally prior to this confirmation.)

GENERALIZED ANXIETY DISORDER

I'M TENSED©

Excessive worry about a number of events occurs most days.
(5 of the 8 symptoms are required, including both as specified*)

IRRITABILITY

MUSCLE TENSION

TOO MUCH WORRY, ANXIETY, FEAR, CONCERN, OR NERVOUSNESS*

EASY FATIGABILITY

NO OR ALMOST NO CONTROL OVER THE WORRY, ANXIETY, ETC.*

SLEEP DISTURBANCE

EDGINESS, FEELING KEYED UP, OR RESTLESSNESS

DIFFICULTY CONCENTRATING OR MIND GOING BLANK

300.02 Generalized Anxiety Disorder (Includes Overanxious Disorder of Childhood)

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling keyed up or on edge

(2) being easily fatigued

(3) difficulty concentrating or mind going blank

(4) irritability

(5) muscle tension

(6) sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

PANIC ATTACKS
SUDDENLY SCARY©

(4 of the 13 symptoms are required)

SHORTNESS OF BREATH

UNREALITY FEELINGS (DEREALIZATION OR DEPERSONALIZATION)

DYING IS FEARED

DISCOMFORT IN THE CHEST OR CHEST PAIN

EVIDENCE OF TREMBLING OR SHAKING

NUMBNESS OR TINGLING SENSATIONS (PARESTHESIAS)

LIGHTHEADED, DIZZY, UNSTEADY OR FAINT

YOU FEAR YOU ARE LOSING CONTROL OR GOING CRAZY

SWEATING

CHILLS OR HOT FLUSHES

ABDOMINAL DISTRESS OR NAUSEA

RAPID HEART BEAT, PALPITATIONS, OR POUNDING HEART

YOU FEEL YOU ARE CHOKING

300.01 Panic Disorder Without Agoraphobia

A. Both (1) and (2):

(1) recurrent unexpected Panic Attacks—Discrete periods of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

(a) palpitations, pounding heart, or accelerated heart rate
(b) sweating
(c) trembling or shaking
(d) sensations of shortness of breath or smothering
(e) feeling of choking
(f) chest pain or discomfort
(g) nausea or abdominal distress
(h) feeling dizzy, unsteady, lightheaded, or faint
(i) derealization (feelings of unreality) or depersonalization (being detached from oneself)
(j) fear of losing control or going crazy
(k) fear of dying
(l) paresthesias (numbness or tingling sensations)
(m) chills or hot flushes

(2) at least one of the attacks has been followed by one month (or more) of one (or more) of the following:

(a) persistent concern about having additional attacks
(b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")
(c) a significant change in behavior related to the attacks

B. Absence of Agoraphobia (anxiety about being in places or situations from which escape might be difficult or embarrassing or help not available)

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occuring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

SOCIAL PHOBIA
FEARS©

FEAR OF ONE OR MORE SOCIAL OR PERFORMANCE SITUATIONS IN WHICH THE PERSON IS FACED WITH

EXPOSURE TO UNFAMILIAR PEOPLE OR TO POSSIBLE SCRUTINY BY OTHERS ALMOST ALWAYS PROVOKES

ANXIETY OR PANIC ATTACKS. NOTE: IN CHILDREN, ANXIETY MAY BE EVIDENT BY CRYING, TANTRUMS, FREEZING, OR WITHDRAWING.

RECOGNITION BY THE PERSON THAT FEAR IS EXCESSIVE OR UNREASONABLE. NOTE: IN CHILDREN THIS FEATURE MAY BE ABSENT.

SOCIAL OR PERFORMANCE SITUATIONS ARE AVOIDED OR ELSE ARE ENDURED WITH INTENSE ANXIETY OR DISTRESS.

300.23 Social Phobia (Social Anxiety Disorder)

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. **Note:** In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder with or without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

Generalized: if the fears include most social situations (e.g., initiating or maintaining conversations, participating in small groups, dating, speaking to authority figures, attending parties). **Note:** Also consider the additional diagnosis of Avoidant Personality Disorder.

OBSESSIVE-COMPULSIVE DISORDER RITUALS©

(Obsessions require first 4, compulsions next 2, both require last 1)

RECURRENT AND PERSISTENT THOUGHTS, IMPULSES, OR IMAGES CAUSE MARKED ANXIETY OR DISTRESS.

IMPULSES, IMAGES, OR THOUGHTS ARE NOT SIMPLY EXCESSIVE WORRIES ABOUT REAL LIFE PROBLEMS.

THOUGHTS, IMPULSES, OR IMAGES ARE RECOGNIZED AS HIS OR HER OWN AND AT LEAST ONCE AS INTRUSIVE.

UNDOING THOUGHTS, IMPULSES, OR IMAGES BY IGNORING, SUPRESSING, OR NEUTRALIZING IS ATTEMPTED.

ACCORDING TO RIGID RULES OR IN RESPONSE TO AN OBSESSION, REPETITIVE BEHAVIORS OR MENTAL ACTS ARE PERFORMED.

LESSENING OR STOPPING DISTRESS OR DREADED EVENT ATTEMPTED VIA EXCESSIVE OR IDIOSYNCRATIC BEHAVIORS OR MENTAL ACTS.

SIGNIFICANT DISTRESS, DYSFUNCTION, OR TIME SPENT ON OBSESSIONS OR COMPULSIONS RECOGNIZED AT LEAST ONCE AS EXCESSIVE.

300.3 Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions are defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions as defined by (1) and (2):

(1) repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. **Note:** This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than one hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if: **With Poor Insight:** if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable.

ACUTE STRESS DISORDER

THREATS©

TRAUMATIC EVENT INVOLVED ACTUAL OR THREATENED DEATH OR SERIOUS INJURY TO THE PERSON OR OTHERS.

HELPLESSNESS, HORROR, OR FEAR TO AN INTENSE DEGREE WAS THE PERSON'S RESPONSE TO THE TRAUMA.

REEXPERIENCING THE TRAUMA VIA RECURRENT IMAGES, THOUGHTS, DREAMS, ILLUSIONS, FLASHBACKS, RELIVING, OR DISTRESS.

EITHER DURING OR AFTER THE DISTRESSING EVENT, THE PERSON HAS THREE (OR MORE) DISSOCIATIVE SYMPTOMS.

ANXIETY OR HYPERAROUSAL (INSOMNIA, ANGER, POOR CONCENTRATION, HYPERVIGILANCE, STARTLING, RESTLESSNESS) IS MARKED.

THOUGHTS, FEELINGS, TALKING, ACTIVITIES, PEOPLE, PLACES, OR STIMULI THAT AROUSE RECOLLECTIONS ARE AVOIDED.

SIGNIFICANT DISTRESS OR IMPAIRMENT SOCIALLY, AT WORK, IN OTHER AREAS OF FUNCTIONING, OR IN TASK COMPLETION.

308.3 Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

(1) a subjective sense of numbing, detachment, or absence of emotional responsiveness

(2) a reduction in awareness of his or her surroundings (e.g., "being in a daze")

(3) derealization

(4) depersonalization

(5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

POSTTRAUMATIC STRESS DISORDER
CRASH©

CRISIS, CRIME, COMBAT, TRAGEDY, OR TRAUMA CAUSES INTENSE FEAR, HELPLESSNESS, OR HORROR AND IS

REEXPERIENCED WITH REPETITIVE, UPSETTING MEMORIES, DREAMS, OR FEELINGS WHEN EXPOSED TO TRAUMA CUES.

AVOIDANCE OF STIMULI ASSOCIATED WITH THE TRAUMA AND NUMBING OF GENERAL RESPONSIVENESS IS SEEN.

SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING IS PRESENT.

HYPERAROUSAL IS EVIDENCED BY INSOMNIA, HYPERVIGILANCE, ANGER, STARTLE RESPONSE, OR POOR CONCENTRATION.

309.81 Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
   (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
   (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating
   (4) hypervigilance
   (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

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

Specify if: **Acute:** symptoms less than 3 months. **Chronic:** symptoms 3 months or more.
Specify if: **With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor.

ADJUSTMENT DISORDERS

EMOTES©

EMOTIONAL OR BEHAVIORAL SYMPTOMS DEVELOPED WITHIN THREE MONTHS OF THE ONSET OF THE STRESSOR WITH

MARKED DISTRESS IN EXCESS OF WHAT WOULD BE EXPECTED FROM EXPOSURE TO THE STRESSOR OR

OCCUPATIONAL, ACADEMIC, OR SOCIAL FUNCTIONING IS SIGNIFICANTLY IMPAIRED.

TERMINATION OF SYMPTOMS OCCURS WITHIN SIX MONTHS OF TERMINATION OF THE STRESSOR (OR ITS CONSEQUENCES).

EXACERBATION OF AN OLD AXIS I OR II ILLNESS OR A NEW STRESS RELATED AXIS I ILLNESS EXCLUDES THIS DIAGNOSIS.

SYMPTOMS DO NOT REPRESENT BEREAVEMENT.

Adjustment Disorders

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

(1) marked distress that is in excess of what would be expected from exposure to the stressor

(2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if:

Acute: if the disturbance lasts less than 6 months

Chronic: if the disturbance lasts for 6 months or longer. By definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The Chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences.

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV.

309.0 With Depressed Mood
309.24 With Anxiety
309.28 With Mixed Anxiety and Depressed Mood
309.3 With Disturbance of Conduct
309.4 With Mixed Disturbance of Emotions and Conduct
309.9 Unspecified

PAIN DISORDER

PAINS©

PAIN IN ONE OR MORE ANATOMICAL SITES IS THE PREDOMINANT FOCUS OF THE CLINICAL PRESENTATION AND IS OF SUFFICIENT SEVERITY TO WARRANT CLINICAL ATTENTION.

ANXIETY, MOOD, OR PSYCHOTIC DISORDER DOES NOT BETTER ACCOUNT FOR THE PAIN, AND THE PAIN DOES NOT MEET CRITERIA FOR DYSPAREUNIA.

IMPORTANT ROLE IDENTIFIED FOR PSYCHOLOGICAL FACTORS IN THE ONSET, SEVERITY, EXACERBATION, OR MAINTENANCE OF THE PAIN.

NO INTENTIONAL PRODUCTION OR FEIGNING OF THE SYMPTOMS OR DEFICIT (AS FOUND IN FACTITIOUS DISORDER OR MALINGERING).

SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING IS CAUSED BY THE PAIN.

307.8x Pain Disorder

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

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

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:

307.80 Pain Disorder Associated with Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medical condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:

Acute: duration of less than 6 months **Chronic:** duration of 6 months or longer

307.89 Pain Disorder Associated With Both Psychological Factors and a General Medical Condition: both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:

Acute: duration of less than 6 months **Chronic:** duration of 6 months or longer

Note: The following is not considered to be a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated With a General Medical Condition: a general medical condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established—for example, low back (724.2), sciatic (724.3), pelvic (625.9), headache (784.0), facial (784.0), chest (786.50), joint (719.40), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0)

PRIMARY INSOMNIA
SLEEP©

SLEEP DISTURBANCE (OR ASSOCIATED DAYTIME FATIGUE) CAUSES CLINICALLY SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT FUNCTIONING.

LASTING FOR AT LEAST ONE MONTH, THE PREDOMINANT COMPLAINT IS DIFFICULTY INITIATING SLEEP, DIFFICULTY MAINTAINING SLEEP, OR NONRESTORATIVE SLEEP.

EXCLUDE PRIMARY INSOMNIA AS THE DIAGNOSIS IF THIS DISTURBANCE OCCURS AS A MANIFESTATION OF AND EXCLUSIVELY DURING THE COURSE OF ANOTHER MENTAL DISORDER.

EXCLUDE DIAGNOSIS IF DISTURBANCE OCCURS EXCLUSIVELY DURING NARCOLEPSY, BREATHING-RELATED SLEEP DISORDER, CIRCADIAN RHYTHM SLEEP DISORDER, OR A PARASOMNIA.

PHYSIOLOGICAL EFFECTS OF A SUBSTANCE (E.G., A DRUG OF ABUSE, A MEDICATION) OR A GENERAL MEDICAL CONDITION DO NOT DIRECTLY CAUSE THE SLEEP DISTURBANCE.

TRAUMA TRIANGLE©

PAIN DISORDERS

HEADACHE
DISCOGENIC
NEUROPATHIC
PSYCHOLOGICAL
MUSCULOSKELETAL
ACUTE, CHRONIC, OR EXACERBATED

HEAD INJURY

SEIZURE DISORDERS
MEMORY IMPAIRMENT
INTELLECTUAL IMPAIRMENT
IMPULSIVITY & INATTENTION
EXECUTIVE FUNCTION DEFICITS
SECONDARY MENTAL DISORDERS

MENTAL DISORDERS

SUBSTANCE-RELATED DISORDERS
DISSOCIATIVE DISORDERS
ADJUSTMENT DISORDERS
PSYCHOTIC DISORDERS
ANXIETY DISORDERS
MOOD DISORDERS

The Trauma Triangle©, reflecting the importance of a holistic approach to treating patients who are victims of trauma, is based on the following:

Harold I. Kaplan, M.D. and Benjamin J. Sadock, M.D., *Kaplan & Sadock's Synopsis of Psychiatry, Behavioral Sciences/Clinical Psychiatry*, Eighth Edition (Philadelphia, Williams & Wilkins, 1998).

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Copyright 2000, American Psychiatric Association, including, among others, the following diagnostic codes: 293.81-293.82 Psychotic Disorders Due to a General Medical Condition, 293.83 Mood Disorder Due to Head Trauma, 293.89 Anxiety Disorder Due to Head Trauma, 293.9 Mental Disorders Not Otherwise Specified Due to a General Medical Condition, 294.0 Amnestic Disorder Due to Head Trauma, 294.9 Cognitive Disorder Not Otherwise Specified: Postconcussional Disorder, 294.11 Dementia Due to Head Trauma with Behavioral Disturbance, 296.20-296.36 Major Depressive Disorders, 300.02 Generalized Anxiety Disorder, 307.80 Pain Disorder Associated with Psychological Factors, 307.89 Pain Disorder Associated with Both Psychological Factors and a General Medical Condition, 309.81 Posttraumatic Stress Disorder, 310.1 Personality Change Due to a General Medical Condition, 780.5x Sleep Disorder Due to a General Medical Condition, as well as, Dissociative Disorders, Pain Disorder Associated with a General Medical Condition, and Sexual Dysfunction Due to a General Medical Condition

Thomas W. McAllister, MD, and Ronald L. Green, MD,"Neurobehavioral Consequences of Traumatic Brain Injury," *Seminars in Clinical Neuropsychiatry*, Vol.3, No 3, (July 1998).

POSITIVE SYMPTOMS OF SCHIZOPHRENIA
SHE GLADLY HALLUCINATES©

SUSPICIOUSNESS

HOSTILITY

EXCITEMENT

GRANDIOSITY

LOOSE

ASSOCIATIONS

DELUSIONS

LIKE
Y'S { CONCEPTUAL DISORGANIZATION IN ADDITION TO LOOSE ASSOCIATIONS INCLUDE: CIRCUMSTANTIALITY, TANGENTIALITY, NONSEQUITURS, GROSS ILLOGICALITY, AND THOUGHT BLOCKING

HALLUCINATIONS

NEGATIVE SYMPTOMS OF SCHIZOPHRENIA
RAPPORT PAST BLASÉ©

RAPPORT IS POOR

PASSIVE/APATHETIC SOCIAL WITHDRAWAL

ABSTRACT THINKING DIFFICULTIES

STEREOTYPED **T**HINKING

BLUNTED **A**FFECT

SPEECH LACKS SPONTANEITY

EMOTIONAL WITHDRAWAL

The Positive and Negative Syndrome Scale (PANSS©) is widely used to assess Schizophrenia illness severity. The items used to create these two mnemonics, SHE GLADLY HALLUCINATES and RAPPORT PAST BLASÉ, although based on the PANSS, are not exactly written as found on the PANSS Quick Score™ which is owned by MHS, Toronto, © 1992, Multi-Health Systems, Inc., 416-492-2627. Fax: 416-492-3343. All rights reserved. Reproduced with permission.

295.x0 Schizophrenia

A. *Characteristic symptoms:* Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):
(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. *Social/occupational dysfunction:* For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. *Duration:* Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e. active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. *Schizoaffective and Mood Disorder exclusion:* Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. *Substance/general medical condition exclusion:* The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. *Relationship to a Pervasive Developmental Disorder:* If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Subtypes: **295.30 Paranoid Type**
295.10 Disorganized Type
295.20 Catatonic Type
295.90 Undifferentiated Type
295.60 Residual Type

For classification of longitudinal course, see DSM-IV-TR™

Mechanism of Action of the SEROTONIN DOPAMINE ANTAGONISTS P.S. I SAID IT. I'M CNS.©

PRE-

SYNAPTICALLY,

INTERESTINGLY,

SEROTONIN

ANTAGONISM

INCREASES

DOPAMINE TRANSMISSION

IN THE

TUBERO-

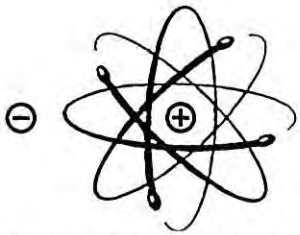
INFINDIBULAR, THE

MESO-

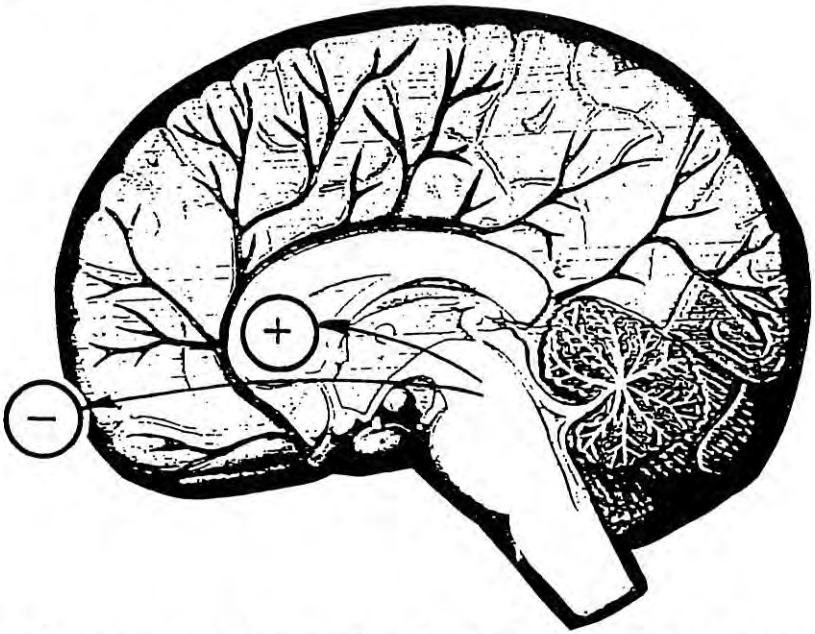
CORTICAL, AND THE

NIGRO-

STRIATAL PATHWAYS.



Just as an atom is positively charged on the inside and negatively charged on the outside,



the increase in dopamine in the mesolimbic system causes the positive symptoms of schizophrenia, and

the decrease of dopamine in the mesocortical system causes the negative symptoms of schizophrenia.

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER
THE SEVEN I'S OF AD/HD COMBINED TYPE©

attentIon-defIcIt/hyperactIvIty dIsorder, combIned type

IMPULSIVITY
INATTENTION, AND AN
INABILITY TO SIT STILL TO A DEGREE THAT IS
INCONSISTENT WITH DEVELOPMENTAL AGE AND MALADAPTIVE.
IMPAIRMENT FROM SOME SYMPTOMS WAS PRESENT BEFORE AGE 7.
IMPAIRMENT IS PRESENT IN TWO OR MORE SETTINGS, AND
IMPAIRMENT IS SIGNIFICANT AT SCHOOL, AT WORK, OR SOCIALLY.

OBSESSIVE-COMPULSIVE DISORDER
REPEATER MRS. PETER©

Obsessions require *REPEATER;* compulsions require *MRS.;* both require *PETER*

RECURRENT AND PERSISTENT THOUGHTS, IMPULSES, OR IMAGES ARE
EXPERIENCED AT SOME TIME DURING THE DISTURBANCE AS INTRUSIVE AND INAPPROPRIATE. THE
PERSON ATTEMPTS TO IGNORE, SUPPRESS, OR NEUTRALIZE THESE THOUGHTS, IMPULSES, OR IMAGES. THE
EXCESSIVE THOUGHTS, IMPULSES, OR IMAGES ARE NOT SIMPLY WORRIES ABOUT REAL-LIFE PROBLEMS.
ANXIETY OR DISTRESS IS MARKED DUE TO THESE THOUGHTS, IMPULSES, OR IMAGES.
THOUGHTS, IMPULSES, OR IMAGES ARE RECOGNIZED NOT TO BE
EXTERNALLY IMPOSED, AND
RECOGNIZED TO BE A PRODUCT OF HIS OR HER OWN MIND.

MENTAL ACTS, (E.G., PRAYING, COUNTING, REPEATING WORDS SILENTLY) OR
REPETITIVE BEHAVIORS (E.G., HAND WASHING, ORDERING, CHECKING) COMPULSIVELY
SERVE (UNREALISTICALLY) TO PREVENT OR REDUCE STRESS OR PREVENT SOME DREADED EVENT OR SITUATION.

PERSONAL RECOGNITION OCCURS AT SOME POINT THAT THE OBSESSIONS OR COMPULSIONS ARE
EXCESSIVE OR UNREASONABLE (EXCEPT PERHAPS IN CHILDREN),
TIME CONSUMING, AND CAUSE MARKED DISTRESS OR SIGNIFICANTLY INTERFERE WITH LIFE.
EATING DISORDERED PATIENT'S PREOCCUPATION WITH FOOD, SUBSTANCE USER'S OBSESSION WITH DRUGS OR THE
RUMINATIONS OF A DEPRESSED PATIENT, ETC., ARE NOT THE SOLE CONTENT OF THE OBSESSION OR COMPULSION.

PERSONALITY DISORDERS

Paranoid Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Antisocial Personality Disorder
Borderline Personality Disorder
Histrionic Personality Disorder
Narcissistic Personality Disorder
Avoidant Personality Disorder
Dependent Personality Disorder
Obsessive-Compulsive Personality Disorder

301.0 PARANOID PERSONALITY DISORDER

SUSPECT©

A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, as indicated by four (or more) of the following:

SUSPECTS, WITHOUT SUFFICIENT BASIS, THAT OTHERS ARE EXPLOITING, HARMING, OR DECEIVING HIM OR HER

UNWARRANTED FEAR THAT INFORMATION WILL BE USED MALICIOUSLY AGAINST HIM OR HER CAUSES RELUCTANCE TO CONFIDE IN OTHERS

SUSPICIOUS, RECURRENTLY, WITHOUT JUSTIFICATION, REGARDING FIDELITY OF SPOUSE OR SEXUAL PARTNER

PERSISTENTLY BEARS GRUDGES, I.E., IS UNFORGIVING OF INSULTS, INJURIES, OR SLIGHTS

EXCESSIVE PREOCCUPATION WITH UNJUSTIFIED DOUBTS ABOUT THE LOYALTY OR TRUSTWORTHINESS OF FRIENDS OR ASSOCIATES

COUNTERATTACKS OR QUICKLY REACTS ANGRILY WHEN PERCEIVES ATTACKS ON HIS OR HER CHARACTER OR REPUTATION THAT ARE NOT APPARENT TO OTHERS

THREATENING OR HIDDEN DEMEANING MEANINGS READ INTO BENIGN REMARKS OR EVENTS

301.20 SCHIZOID PERSONALITY DISORDER

DISORDER©

A pervasive pattern of detachment from social relationships and a restricted range of emotional expression that includes:

DESIRES NOR ENJOYS CLOSE RELATIONSHIPS, INCLUDING BEING PART OF A FAMILY

IN FEW, IF ANY, ACTIVITIES, TAKES PLEASURE

SEXUAL EXPERIENCES WITH ANOTHER PERSON ARE OF LITTLE, IF ANY, INTEREST

OTHERS' PRAISE OR CRITICISM ELICITS INDIFFERENCE

RELATIVES (FIRST-DEGREE) ARE THE ONLY CLOSE FRIENDS OR CONFIDANTS

DESIRES, AND ALMOST ALWAYS CHOOSES, SOLITARY ACTIVITIES

EMOTIONAL COLDNESS, DETACHMENT, OR FLATTENED AFFECTIVITY SHOWN

REQUIRES FOUR (OR MORE) OF THESE SEVEN CHARACTERISTICS FOR DIAGNOSIS

301.22 SCHIZOTYPAL PERSONALITY DISORDER

PERSONALITY©

PARANOID IDEATION OR SUSPICIOUSNESS

EXPERIENCES UNUSUAL PERCEPTIONS, INCLUDING BODILY ILLUSIONS

REDUCED CAPACITY FOR, AND ACUTE DISCOMFORT WITH, CLOSE RELATIONSHIPS, RESULTING IN SOCIAL AND INTERPERSONAL DEFICITS WITH COGNITIVE OR PERCEPTUAL DISTORTIONS AND BEHAVIORAL ECCENTRICITIES

SOCIAL ANXIETY DOES NOT DIMINISH WITH FAMILIARITY AND TENDS TO BE ASSOCIATED WITH PARANOID FEARS RATHER THAN NEGATIVE JUDGMENTS ABOUT SELF

ODD, ECCENTRIC, OR PECULIAR BEHAVIOR OR APPEARANCE

NOT CONSISTENT WITH SUBCULTURAL NORMS, ODD BELIEFS OR MAGICAL THINKING INFLUENCE BEHAVIOR

AFFECT IS INAPPROPRIATE OR CONSTRICTED

LACK OF CLOSE FRIENDS OR CONFIDANTS OTHER THAN FIRST-DEGREE RELATIVES

IDEAS OF REFERENCE (EXCLUDING DELUSIONS OF REFERENCE)

THINKING AND SPEECH ARE ODD (E.G., VAGUE, CIRCUMSTANTIAL, METAPHORICAL, OVERELABORATE, OR STEREOTYPED)

YOU NEED FIVE (OR MORE) OF THESE NINE CRITERIA PLUS **"R"** FOR THIS DIAGNOSIS

301.7 ANTISOCIAL PERSONALITY DISORDER

DISREGARD©

DISREGARD FOR AND VIOLATION OF THE RIGHTS OF OTHERS SINCE AGE 15 YEARS PRESENT AS A PERVASIVE PATTERN

IMPULSIVITY OR FAILURE TO PLAN AHEAD

SAFETY OF SELF OR OTHERS RECKLESSLY DISREGARDED

REPEATED FAILURE TO SUSTAIN CONSISTENT WORK BEHAVIOR OR HONOR FINANCIAL OBLIGATIONS AND DEMONSTRATES CONSISTENT IRRESPONSIBILITY

EVIDENCE OF THE FIRST **"D"** PLUS 3 (OR MORE) OF THESE 7 CRITERIA NEEDED FOR DIAGNOSIS

GROUNDS FOR ARREST INDICATED BY REPEATEDLY PERFORMING ACTS AND FAILING TO CONFORM TO SOCIAL NORMS WITH RESPECT TO LAWFUL BEHAVIORS

AGGRESSIVENESS AND IRRITABILITY, AS INDICATED BY REPEATED PHYSICAL FIGHTS OR ASSAULTS

REMORSE LACKING, AS INDICATED BY BEING INDIFFERENT TO OR RATIONALIZING HAVING HURT, MISTREATED, OR STOLEN FROM ANOTHER

DECEITFULNESS, AS INDICATED BY REPEATED LYING, USE OF ALIASES, OR CONNING OTHERS FOR PERSONAL PROFIT OR PLEASURE

301.83 BORDERLINE PERSONALITY DISORDER
DISTURBED©

A pervasive pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity with five (or more) of the following:

DISTURBANCE OF IDENTITY: MARKEDLY AND PERSISTENTLY UNSTABLE SELF-IMAGE OR SENSE OF SELF

INSTABILITY OF AFFECT DUE TO A MARKED REACTIVITY OF MOOD (E.G., INTENSE EPISODIC DYSPHORIA, IRRITABILITY, OR ANXIETY USUALLY OF BRIEF DURATION)

SELF-DAMAGING IMPULSIVITY IN AT LEAST TWO AREAS (E.G., SPENDING, SEX, SUBSTANCE ABUSE, RECKLESS DRIVING, BINGE EATING). NOTE: DO NOT INCLUDE **"B"**

TRANSIENT, STRESS-RELATED PARANOID IDEATION OR SEVERE DISSOCIATIVE SYMPTOMS

UNSTABLE AND INTENSE INTERPERSONAL RELATIONSHIPS CHARACTERIZED BY ALTERNATING BETWEEN EXTREMES OF IDEALIZATION AND DEVALUATION

REAL OR IMAGINED ABANDONMENT FRANTICALLY AVOIDED. NOTE: DO NOT INCLUDE **"B"**: SUICIDAL OR SELF-MUTILATING BEHAVIOR

BEHAVIORS THAT ARE SELF-MUTILATING OR RECURRENT SUICIDAL BEHAVIOR, GESTURES, OR THREATS

EMPTINESS CHRONICALLY FELT

DIFFICULTY CONTROLLING ANGER OR INTENSE, INAPPROPRIATE ANGER (E.G., RECURRENT PHYSICAL FIGHTS, CONSTANT ANGER, FREQUENT TANTRUMS)

301.50 HISTRIONIC PERSONALITY DISORDER
SEDUCTIVE©

A pervasive pattern of excessive emotionality and attention seeking as indicated by:

SHALLOW EXPRESSION AND RAPIDLY SHIFTING DISPLAY OF EMOTIONS

EXCESSIVELY IMPRESSIONISTIC STYLE OF SPEECH THAT IS LACKING IN DETAIL

DISCOMFORT IN SITUATIONS IN WHICH HE OR SHE IS NOT THE CENTER OF ATTENTION

USES PHYSICAL APPEARANCE CONSISTENTLY TO DRAW ATTENTION TO SELF

CONSIDERS RELATIONSHIPS TO BE MORE INTIMATE THAN THEY ACTUALLY ARE

THEATRICALLY SELF-DRAMATIZES AND HAS EXAGGERATED EXPRESSION OF EMOTION

INTERACTIONS OFTEN CHARACTERIZED BY INAPPROPRIATE SEXUALLY SEDUCTIVE OR PROVOCATIVE BEHAVIOR

VERIFICATION OF DIAGNOSIS REQUIRES THAT FIVE (OR MORE) OF THESE EIGHT CRITERIA ARE PRESENT

EASILY INFLUENCED BY OTHERS OR CIRCUMSTANCES, I.E., IS SUGGESTIBLE

301.81 NARCISSISTIC PERSONALITY DISORDER

SELF-IMPORT©

SHE OR HE BELIEVES THEY ARE "SPECIAL" AND UNIQUE AND CAN ONLY BE UNDERSTOOD BY, OR SHOULD ASSOCIATE WITH, OTHER SPECIAL OR HIGH-STATUS PEOPLE (OR INSTITUTIONS)

EMPATHY LACKING, GRANDIOSITY PRESENT (IN FANTASY OR BEHAVIOR), AND THE NEED FOR ADMIRATION PRESENT AS A PERVASIVE PATTERN IN A VARIETY OF CONTEXTS

LACKS EMPATHY:IS UNWILLING TO RECOGNIZE OR IDENTIFY WITH THE FEELINGS AND NEEDS OF OTHERS

FAVORABLE TREATMENT OR AUTOMATIC COMPLIANCE WITH HIS OR HER EXPECTATIONS IS UNREASONABLY EXPECTED DUE TO A SENSE OF ENTITLEMENT

INTERPERSONALLY EXPLOITATIVE, I.E., TAKES ADVANTAGE OF OTHERS TO ACHIEVE HIS OR HER OWN ENDS

MUST HAVE FIVE (OR MORE) OF THESE PLUS **"E"** FOR THIS DIAGNOSIS

PREOCCUPIED WITH FANTASIES OF UNLIMITED SUCCESS, POWER, BRILLIANCE, BEAUTY, OR IDEAL LOVE

OFTEN ENVIOUS OF OTHERS OR BELIEVES THAT OTHERS ARE ENVIOUS OF HIM OR HER

REQUIRES EXCESSIVE ADMIRATION

TALENTS AND ACHIEVEMENTS ARE EXAGGERATED, EXPECTS TO BE RECOGNIZED AS SUPERIOR WITHOUT COMMENSURATE ACHIEVEMENTS, HAS A GRANDIOSE SENSE OF SELF-IMPORTANCE

301.82 AVOIDANT PERSONALITY DISORDER

RESERVED©

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation as indicated by:

RELUCTANCE TO TAKE PERSONAL RISKS OR ENGAGE IN ANYTHING NEW BECAUSE IT MAY PROVE EMBARRASSING

EVALUATION REQUIRES FOUR (OR MORE) OF THESE CRITERIA FOR THIS DIAGNOSIS

SHOWS RESTRAINT WITHIN INTIMATE RELATIONSHIPS BECAUSE OF FEAR OF BEING SHAMED OR RIDICULED

EXCESSIVE UNWILLINGNESS TO GET INVOLVED WITH PEOPLE UNLESS CERTAIN OF BEING LIKED

REJECTION OR CRITICISM IN SOCIAL SITUATIONS IS A PREOCCUPATION

VIEWS SELF AS SOCIALLY INEPT, PERSONALLY UNAPPEALING, OR INFERIOR TO OTHERS

EXTREMELY INHIBITED IN NEW INTERPERSONAL SITUATIONS BECAUSE OF FEELINGS OF INADEQUACY

DISAPPROVAL, CRITICISM, OR REJECTION IS SO FEARED THAT HE OR SHE AVOIDS OCCUPATIONAL ACTIVITIES THAT INVOLVE SIGNIFICANT INTERPERSONAL CONTACT

301.6 DEPENDENT PERSONALITY DISORDER

DEPENDENT©

DIFFICULTY MAKING EVERYDAY DECISIONS WITHOUT AN EXCESSIVE AMOUNT OF ADVICE AND REASSURANCE FROM OTHERS

ENDING ONE CLOSE RELATIONSHIP RESULTS IN URGENTLY SEEKING ANOTHER RELATIONSHIP AS A SOURCE OF CARE AND SUPPORT

PROJECT INITIATION OR DOING THINGS ON HIS OR HER OWN IS DIFFICULT (BECAUSE OF A LACK OF SELF-CONFIDENCE IN JUDGMENT OR ABILITIES RATHER THAN A LACK OF MOTIVATION OR ENERGY)

EXCESSIVE LENGTHS ARE GONE TO FOR OBTAINING NURTURANCE AND SUPPORT FROM OTHERS, TO THE POINT OF VOLUNTEERING TO DO THINGS THAT ARE UNPLEASANT

NEEDS OTHERS TO ASSUME RESPONSIBILITY FOR MOST MAJOR AREAS OF LIFE (I.E., DEPENDS ON PARENTS OR SPOUSE TO DECIDE WHERE TO LIVE, WORK, ATTEND COLLEGE, OR WHAT CLOTHES TO WEAR, ETC.)

DIFFICULTY EXPRESSING DISAGREEMENT WITH OTHERS BECAUSE OF FEAR OF LOSS OF SUPPORT OR APPROVAL. NOTE: DO NOT INCLUDE REALISTIC FEARS OF RETRIBUTION

EXAGGERATED FEARS OF BEING UNABLE TO CARE FOR HIMSELF OR HERSELF CAUSES UNCOMFORTABLE FEELINGS OR HELPLESSNESS WHEN ALONE

NEED TO BE TAKEN CARE OF IS PERVASIVE AND EXCESSIVE AND LEADS TO SUBMISSIVE AND CLINGING BEHAVIOR AND FEARS OF SEPARATION INCLUDING FIVE (OR MORE) OF THESE OTHER CRITERIA

THE FEAR OF BEING ABANDONED AND LEFT TO CARE FOR SELF IS AN UNREALISTIC PREOCCUPATION

301.4 OBSESSIVE-COMPULSIVE PERSONALITY DISORDER

COMPULSIVE©

COMPLETING TASKS INTERFERED WITH BY PERFECTIONISM (E.G., IS UNABLE TO COMPLETE A PROJECT BECAUSE HIS OR HER OWN OVERLY STRICT STANDARDS ARE NOT MET)

ORDERLINESS, PERFECTIONISM, AND MENTAL AND INTERPERSONAL CONTROL AT THE EXPENSE OF FLEXIBILITY, OPENNESS, AND EFFICIENCY IS SEEN AS A PERVASIVE PATTERN OF PREOCCUPATION IN A VARIETY OF CONTEXTS

MATTERS OF MORALITY, ETHICS, OR VALUES DEALT WITH THROUGH OVERCONSCIENTIOUS, SCRUPULOUS, AND INFLEXIBLE BEHAVIORS

PREOCCUPIED WITH DETAILS, RULES, LISTS, ORDER, ORGANIZATION, OR SCHEDULES TO THE EXTENT THAT THE MAJOR POINT OF THE ACTIVITY IS LOST

UNLESS OTHERS SUBMIT TO EXACTLY HIS OR HER WAY OF DOING THINGS, IS RELUCTANT TO DELEGATE TASKS OR TO WORK WITH OTHERS

LISTING FOUR (OR MORE) OF THESE PLUS **"0"** IS REQUIRED FOR THIS DIAGNOSIS

SPENDING STYLE TOWARD BOTH SELF AND OTHERS IS MISERLY; MONEY IS VIEWED AS SOMETHING TO BE HOARDED FOR FUTURE CATASTROPHES

IS UNABLE TO DISCARD WORN-OUT OR WORTHLESS OBJECTS EVEN WHEN THEY HAVE NO SENTIMENTAL VALUE

VERY RIGID AND STUBBORN

EXCESSIVE DEVOTION TO WORK AND PRODUCTIVITY TO THE EXCLUSION OF LEISURE ACTIVITIES AND FRIENDSHIPS (NOT ACCOUNTED FOR BY OBVIOUS ECONOMIC NECESSITY)

Leon I. Rosenberg graduated from Harvard University with Honors in Biology in 1974. He earned his Doctor of Medicine degree from SUNY-Upstate Medical School at Syracuse, New York in 1978. He completed an Internship in Psychiatry at Long Island Jewish-Hillside Hospital in 1979, an Adult Psychiatry Residency at the Hospital of the University of Pennsylvania in 1981, and a Child Psychiatry Fellowship at Hahnemann University Hospital in 1983.

Dr. Rosenberg is the Medical Director of the Center for Emotional Fitness, located in Moorestown, New Jersey. He specializes in all aspects of psychiatry including psychopharmacology, individual, marital, family and group therapy, and forensic psychiatry. He and his staff conduct research studies in psychopharmacology. In the past, he was the Acting Chief of the Department of Psychiatry at Memorial Hospital of Burlington County in Mount Holly, New Jersey. He remains on the consulting staff both at Deborah Heart and Lung Center and at Lourdes Medical Center of Burlington County.

Dr. Rosenberg is certified by the American Board of Psychiatry and Neurology in Psychiatry and has added qualifications in Forensic Psychiatry and Geriatric Psychiatry. Dr. Rosenberg is also certified by the American Board of Addiction Medicine and board-eligible in Child Psychiatry.

Dr. Rosenberg's areas of expertise include: Adult, Child, Adolescent and Geriatric Psychiatry; Hypnotherapy; Recognition and Treatment of Depression, Mania and Anxiety Disorders; Forensic Psychiatry; Psychopharmacology; and the Evaluation and Treatment of Victims of Abuse, Accidents and Trauma. He belongs to the American Medical Association, American Psychiatric Association, Burlington County Medical Society, New Jersey Psychiatric Association, American Academy of Psychiatry and the Law, International Society for Traumatic Stress Studies, and he serves on the Camden County Mental Health Board.

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