A Psychiatric Diagnosis Primer:  
An Easy Guide to Identifying Psychiatric Illness  

by  

Gary Solomon, MPH, M.S.W., Ph.D.
Dedication

To all those interested in gaining an understanding of the difficult process of identifying psychiatric presentations. It is my hope that my work will make your journey that much easier.
Acknowledgments

Grateful thanks to all my students who continuously supply me with questions, answers, ideas, and direction regarding this difficult area of psychology.
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Warning

*A Psychiatric Diagnosis Primer: an Easy Guide to Identifying Psychiatric Illness* is designed as a guide to psychiatric disorders, mental health information and data. My book is in no way intended to take the place of a professional; psychiatrist, psychologist, social worker, or therapist. The book should not be used as a final instrument for psychological evaluation, treatment application or intervention by a non-professional. The profession of psychiatry, psychology, social worker, and therapy comes with rigorous academic training, substantial experience and practice background. The reader, whether a professional, or a student, or a lay person must use *The Psychiatric Diagnosis Primer* as a support tool and stepping stone to a greater understanding in recognizing and identifying those who may need to be referred to the aforementioned professionals. Again, you must not transition to a final conclusion regarding an individual’s mental status nor should you take a course of treatment when using *A Psychiatric Diagnosis Primer* without the direction and supervision of a mental health professional. Finally, numerous Internet Resources are identified in *A Psychiatric Diagnosis Primer* to assist you in gathering information regarding an individual psychiatric illness. Many of the Internet Resources contain advertising. NOTE: I am not endorsing or suggesting the purchase or use of any of the products mentioned in the Internet Resources. Simply use the Internet Resources to increase your understanding and knowledge regarding psychiatric disorders and mental health issues.

**FIRST, ALWAYS HAVE A MEDICAL SPECIALIST RULE OUT A POSSIBLE GENERAL MEDICAL CONDITION AS A POSSIBLE CAUSE OF THE BEHAVIOR OR CONDITION BEFORE PROCEEDING TO THE NEXT LEVEL OF INDIVIDUAL EVALUATION OR TREATMENT APPROACH. SECOND, AFTER RULING OUT A GENERAL MEDICAL CONDITION, EVALUATE THE INDIVIDUAL TO LEARN IF THEY ARE EXPERIENCING A SUBSTANCE-RELATED PROBLEM BEFORE PROCEEDING TO THE NEXT LEVEL OF INDIVIDUAL EVALUATION OR TREATMENT APPROACH. THIRD, HAVING RULED OUT A GENERAL MEDICAL CONDITION OR A SUBSTANCE-RELATED DISORDER, MOVE TO ALL THE OTHER POSSIBLE DIAGNOSES IN A GIVEN DIAGNOSTIC CATEGORY.**
Preface

Since I began my academic training in the field of psychology and social work, I have been dissatisfied with the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a universal teaching and educational instrument. The DSM is overwhelmingly difficult for the layperson to comprehend. There is no question that the DSM is designed for the consummate professional trained in the field of psychiatric diagnosis.

Make no mistake; the DSM is an extraordinary book, rich with informational diagnostic building blocks that assist professionals in identifying the wide range of mental diseases affecting the general world population. However, I have believed from the very beginning of my career that the DSM needed to be redesigned and constructed as a more accessible, readable and usable reference instrument for the general public; therapists, teachers, students, non-psychiatric medical professionals, government agencies, parents, employers, business owners, etc.

As a therapist, educator, researcher, and writer, my long range professional goal was to create a user-friendly psychiatric guide for the general population. But there was always a problem standing in my way; the volume of information embodied in the DSM was virtually impossible to condense into an easily readable, friendly instrument. For years I felt defeated; for me, the writing of a new book on the subject of diagnostic disorders was staggering and daunting.

In 2001, I received a copy of a research project dealing with occult psychiatric morbidity. Summarily, the research project indicated that approximately 30% of all emergency room patients go undiagnosed for mental illness; only 5% of those patients with a presenting psychiatric morbidity were recognized by doctors and nurses attending to patients in emergency room facilities. More frustrated than before, I was again reminded of the tremendous need for a user friendly psychiatric diagnostic tool. There simply was no way to convey the necessary information in this specialized field of psychology in layperson’s terms. About to give up, in October of 2004, the solution to the problem came across my desk.

One morning in October of 2004, I received an unassuming e-mail from The Department of Human Resources at The Community College of Southern Nevada. I was invited to make a presentation for the college in what is known as Convocation Week; the week prior to the opening of the college school semester. I didn’t think much of the correspondence; it was just
another e-mail from the college. Walking away from my computer, I decided to take a break from my current book-in-progress. Within a few steps from the computer, I froze in my tracks. Returning to the screen, I stared at the correspondence from The Department of Human Resources but did not reread the e-mail. Suddenly it was as if the sky had opened and the roof of my office was lifted. The clouds that blanketed my ability to see the solution to the aforementioned problems associated with writing my new book on psychiatric diagnosis suddenly vanished. I immediately switched screens and began writing, *A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness*.

For the first time since the release of the first edition of the DSM and other books on psychiatric diagnosis, you, the therapist, teacher, student, non psychiatric medical professional, parents, employer, business owner, etc., will be able to identify psychiatric problems and presenting psychiatric issues in the general population with my easy to use, easy to read book, *A Psychiatric Diagnosis Primer*. Although the book is not intended to turn you into a professional psychiatric diagnostician, you will have the knowledge at hand to recognize and identify individual psychological issues and problems.

No matter who you are, professional or layperson, the ability to recognize psychiatric problems and issues is now at your fingertips. *A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness* will assist you in any environment, professional or personal, and help you to recognize and understand the behavior of those around you. Even if you decided to skip the introduction of my book– please do not skip the **Warning** in the front of the book–you will quickly understand my simple and easy way to use *A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness*.

Gary Solomon, MPH, M.S.W., Ph.D., Professor of Psychology
Introduction

As a former chief executive officer of a multinational corporation, psychotherapist, and currently an author and Professor of Psychology at The College of Southern Nevada, I have encountered a wide variety of academic and work environments. There is no question that a single theme persists in all human milieus: psychiatric morbidity, more commonly known as mental illness.

Mental illness accounts for an untold loss of business and personal income, marital disillusionment, school attrition, and physical harm including death. In spite of the worldwide pervasive nature of mental illness, few have any idea how to identify and categorize these psychiatric problems in our environment. Additionally, once the psychological problem is recognized, confronting and treating the individual with presenting mental health issue(s) is often overlooked.

*A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness* is the first book of its type written for non-psychiatric medical professionals, therapists, attorneys, employers, teachers, students, parents, etc., to assist them in identifying and taking action relating to problem presentations of mental illness. My book is designed to assist individuals and groups with the quick identification of mental illness. Additionally, my book supplies the reader with instant information on how and where to seek support for those who may be suffering from a mental health problem. However, I must begin with an important message; my book comes with a **Warning**:

*A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness* does not replace the work and skills of a trained professional. You should not come to a final conclusion regarding an individual’s mental status without consulting someone who is skilled in the area of diagnosis and treatment of psychiatric problems.

Although *A Psychiatric Diagnosis Primer* does not turn you into a professional diagnostician, my book does allow you to make an educated evaluation of a presenting mental health problem or situation making a presentation in a wide range of milieus; work, home, school, public settings, etc. Offered in an easy-to-read, easy-to-understand model, you will be able to quickly access psychiatric diagnostic information.

About Mental Illness

Let me begin by saying that mental illness is a complex area of medicine and the human condition. Of all the many organs in the human body, the brain, the center all mental illness, is the least understood of all. Because of this fact, mental illness and emotionally-based problems continue to be an enigma in the worldwide population. While research continues to uncover the mystery of mental illness, true understanding of origin and etiology of mental health problems appears to be far in the future. However, clinicians have reached a point where it is possible to identify and attempt to treat a wide range of mental health problems; psychiatric morbidity.

Academics, researchers and clinicians have spent decades compiling information on the hundreds of complex mental illnesses that affect humans all over the world. There are literally a plethora of volumes of work dealing with everything from childhood psychological problems and adult mental dysfunction to mental health presentations of the mentally retarded and the
elderly. It is extremely important for you to understand that condensing the wide and varied mental health diagnostic presentations into a single text borders on the impossible.

All humans suffer from psychological problems. Being stressed about work, having too much to drink, unable to sleep, feeling sad and depressed, coping with a child’s behavior, being anxious over the ending of a relationship, and coping with the death of a loved one are but a few examples of the many psychological problems that may be presented in a single day in the lives of most people. But there are a few rules and guidelines that are used when attempting to identify whether or not the perceived problem is a diagnosable mental illness.

First, is the perceived problem bothering or interrupting your life or the life of the individual being observed as having a mental health problem? That is: Is the mental health issue a problem for the person whom you perceive as having the problem? Second, is the presentation made by you or the individual considered normal within their culture? That is: Is it reasonable for others to expect you or the individual to act and present themselves in a more socially acceptable, predictable manner? Finally, are you or the individual being observed unhappy, discontent, with your life as a result of the perceived problem? Simply stated: Do you or the individual under observation want to change due to unhappiness? Let’s look at a few examples to explain this fundamental concept and possible concurrent conundrum.

Harry is a 45-year-old male who sleeps three hours a night. He has a high pressure job. Question: Is Harry’s lack of sleep a mental health problem? It is, only if it bothers Harry; if it makes him unhappy. Harry may be quite happy with his sleep pattern. However, Harry’s significant other may suffer from sleep interruption and deprivation as a result of Harry’s sleep pattern. And, as a result, his significant other may suffer from sleep deprivation that, in fact, does cause a diagnosable mental illness in her. Accordingly, the illness may cause Harry to become stressed and pressured which in turn creates a mental illness for Harry. Sound a bit complicated? In this case, the very thing that most people would consider a problem was not a problem or issue at all for Harry. The mental health issues that came about for Harry was from extraneous or secondary factors. And, in this case, it is the issue of stress that may need to be treated. Let’s try another example.

Barbara is a 26 year old female. She is discontent with her gender; she believes she would be happier as a male. Given her presenting information she would probably be diagnosed with a mental disorder referred to as Gender Identity Disorder. Now, most clinicians would accept and treat this as a mental disorder. But first, we must ask a fundamental question: Is Barbara’s discontentment interrupting her life? Is she so unhappy that she is not living her life in a normal manner? I will argue that if she accepts her discontent and it is not affecting her normal living, then this presentation is not a mental disorder. The bottom line is, she seems to be happy overall. Furthermore, should she decide to have a gender change–change from having female genitalia to having male genitalia–she may not experience any discontentment at all. Now that she is identified as a male, should he receive a diagnosis of Gender Identity Disorder? Does he meet the guidelines for a diagnosable mental illness? I don’t think he should. Let’s do one more.

Robert loves his life. He has a job as a computer analyst. He gets up, goes to work, works all day by himself, goes home, watches television and goes to sleep. On the weekends, he is alone. He does not date or visit friends. If he is in a group of people, he feels uneasy. He does not even like to eat around other people. Question: Does Robert have a diagnosable problem? Many would say that Robert suffers from a diagnosis of Avoidant Personality Disorder, Social Phobia or both. But remember, Robert loves his life. If you ask him if he is
happy, Robert says, “Yes”. If you ask him if he wants to change his life, he says, “No”. Again, if it is not a problem for Robert then we might argue that Robert does not have a problem and therefore does not deserve a mental health diagnosis. But we have another problem; one that may offer the foundation for an argument contrary to this position. Reading the three aforementioned examples, you may have noticed the problem.

While the individual does not believe they have a problem with their life, behavior or diagnosable condition as perceived by outsiders, we must ask an overriding question: Is what the individual is experiencing in their life considered normal? Now you see I really ask another question that embraces yet another issue. It is not simply good enough for the individual to consider their behavior normal. Rather, does the culture in which the individual resides view the behavior as normal?

Simply because Joanne enjoys drinking herself into a stupor every day and because it doesn’t bother her, is there a problem? Does she deserve a diagnosis, in the category of Substance-Related Disorders, or Alcohol Abuse, Dependence or Intoxication? If Arthur gains sexual pleasure from receiving pain while engaging in sexual activity, should he receive a diagnosis of Sexual Masochism in the category of Sexual Disorders even though it does not bother him and he receives pleasure from his behavior? If Mary elects to eat 550 calories a day, does she have the Eating Disorder, Anorexia, if in her mind, her eating habits are a normal lifestyle to her? Each of these questions begs the question: What is normal?

Many people enjoy the debate over what is normal. Is there anything such as normal? If there is a concept called normal. And, who will define the concept of normal? Can we define normal for everyone or is normal an individual belief? Well, I now offer you an answer and guidelines to deal with the conundrum: What is normal and who will make the delineation of the range of normality?

Normal is defined by the culture where the individual resides or is visiting. Most of you are familiar with the phrase: “When in Rome, do as the Romans do”. Well, this is a solid statement of the concept of defining normal. Normal is the place where you are at any given time.

While it would be abnormal for someone in an inner city of the United States to have a cow in their backyard, it would be quite normal for a farmer in the mid west to raise cattle as a hobby or as a business. However, if that farmer believes his cows have religious meaning, this belief would be considered, abnormal and he may be shunned by the surrounding community. But, it may be a spiritual practice for someone in India to live with a cow on their property believing the cow has a strong religious meaning to the cow’s owner and the community where the cow resides.

There are places in the world where a circumcision is a rite of passage. When a boy turns twelve, a knife-weeding Shaman will ritualistically remove the foreskin of the penis in a painful and potentially deadly rite of passage from childhood to manhood. For their culture, this behavior is normal. If such an act took place in the Western World, it would be considered abnormal and sadistic, punishable by imprisonment or removal of the child from the household of the parents practicing this rite of passage. However, a parent may employ a licensed physician to perform the circumcision without fear of legal reprisal. Accordingly, in this case, the behavior would be considered normal.

In some cultures, it is normal to grieve the loss of a loved one for one or two years. Yet, in other cultures people are expected to “get over it” and move on. Extending the grieving process may be interrupted as a sign of weakness. There are a few places in the world where
people eat body parts of a dead loved one. For them, this behavior is an act of love and tradition. And even though most world societies would refer to this as abhorrent and unthinkable cannibalism, for those people who practice this belief, they are being normal. In fact, not eating a piece of a dead loved one may be abnormal and unacceptable to others living in the culture.

I could continue with example after example, but I think you can get the point: Normal is defined by the culture where the individual lives or is visiting. It is when an individual or group behaves or functions in a manner that is outside the range of normality that is defined by the current culture, that the individual or group is considered abnormal. Now this concept can be further defined regionally. Let’s use the United States of America as an example.

In some parts of the country, it’s lights out by 9:00 PM. These communities may consider good, healthy, normal living to be, ‘Early to Bed and Early to Rise’. Now, let’s take a flight to Las Vegas, Nevada, the home of, ‘What Happens Here Stays Here’. Do you think that people in Las Vegas believe it is abnormal to turn the lights out by 9:00 PM? Quite to the contrary, Las Vegas is the party capital of the world; staying up all night long is defined as normal and expected in the community; there is nothing abnormal about living a 24 hour lifestyle in Las Vegas. And what about living in Alaska? Is it normal to live in the dark six months out of the year? Absolutely. That is the way people survive in that part of the world. Therefore, normal is also defined regionally by the way individuals and groups live and function not by the way people in other regions live. That is, the culture is defined by the region where people live and therefore, that region and its inhabitants define normality.

An adult engaging in sexual activity with a minor–someone under the age of sixteen–is considered abnormal and illegal. Add to this behavior, engaging in sexual activity with a family member who is a minor and this makes this type of sexual practice even more abnormal. This would be an act of incest and molestations in the minds of most Americans and the individual would be referred to as an incestuous pederast (pedophile). Yet, there are those who grew up in homes where they engaged in sexual activity with a parent, sibling or other relatives and carry this tradition to the next generation of children and adults. When these children and adults are interviewed with respect to their thinking and behavior regarding this type of sexual activity they make reference to believing that, for them, the behavior was and is normal. “That’s how I grew up.” “That’s what my parents taught me.” “I didn’t think it was wrong.” “Having sex with my child is normal.” For most, simply reading these thoughts and statements is beyond disturbing and is thought of as an unconscionable behavior. But is the behavior normal? The answer is complex. Why? Because for this family subculture, the behavior is normal; part of a family tradition. But in the greater culture, the behavior is abnormal and, therefore, it is illegal; the general community will ostracize those who participate, willingly or unwillingly.

As we work to define the concept of normal, we must embrace the beliefs and laws within the community where we live. Should a group decide to commit suicide–such events have occurred–the practice would be considered abnormal. But the group having decided to commit this collective act of suicide would call their behavior normal, if not spiritual and enlightened.

So let us have a consistent understanding of the concept of normal. For the purpose of this text, normal is defined as: Behaviors and beliefs that are consistent and predictable within a cultural group or subgroup that are not illegal or significantly set apart from the general practice and expectations of the members of that culture as a whole. Therefore, what the individual is doing is considered normal. Now, given this understanding let’s return to our previous examples.
Remember Harry? He sleeps three hours a night and is perfectly content with the amount of sleep he experiences in a 24 hour period. Yet, in the United States, sleeping three hours a night is abnormal. The individual may be diagnosed with a mental health disorder such as Sleep Apnea under the category of Sleep Disorders even though he reports little or no discomfort. This is a cultural abnormality not an individual normality.

How about Barbara? Remember Barbara does not feel like she is a woman, but rather a man. United States culture dictates that this is a Gender Identity Disorder under the category of Sexual Disorders. Yet, Barbara is not significantly disturbed by her feelings. And when Barbara has an operation to change her gender, he is now perfectly happy. Again, this is a cultural abnormality not an individual normality. And let’s not forget Robert. His lifestyle is culturally abnormal. Yet, he reports being perfectly content with his life. Once more, Robert would be diagnosed with a mental health disorder. As you probably recognize, the rules are volatile with little or no science to support a fixed truth. Now we have another problem.

Unlike the hard sciences, the soft science of psychology does not have the luxury of a fixed set of rules on its side; there are few if any hard and fast rules that govern the field of psychology. A pound is a pound the world over. That is hard science. Two plus two equals four. That is hard science. Energy equals mass times the speed of light squared (E=MC²). That is hard science. No matter where you go in the world, the aforementioned rules are always true; they never vary on earth. Being “always true” is the nature of hard science. But psychology is void of such rules.

If you grow up without a father and start drinking at the age of ten and drop out of school when you are fourteen, is it possible to predict what your psychological state of mind will be in a culture? No, absolutely not. If you are attacked, beaten and robbed and end up in a coma for a year, is it possible to predict what your psychological status will be upon wakening? No. If someone has killed four people over a ten year period of time is it possible to predict if the individual will kill again? Can I predict his psychological status? The answer is a resounding, no. And until such time as the fields of psychiatry and psychology are able to capture the rules of hard science–predictability–we will be left to the opinions and beliefs within a given culture.

Now, here is your last concept to embrace with respect to normal and abnormal. All psychological functioning and dysfunctioning operates on a continuum. It is rare for someone to shift from a state of normality to abnormality in an instant. A trauma may cause this rapid shift in a small number of individuals. In most cases, individuals and groups move, with some level of volatility, on a continuum of varying states of normality to abnormality and back to normality, though some will remain in a state of abnormality for their entire lives. Again, this normality and abnormality is defined by the community–group or subgroup–where the person resides. The following explanation and graph will supply you with a greater understanding of neurosis and psychosis on a normality/abnormality continuum.

From Neurosis to Psychosis

Many people, even mental health professionals, do not truly understand the difference between a neurosis and a psychosis. Understanding the difference between a neurosis and psychosis is to understand the significant difference between a mild to moderate mental disorder and a severe mental disorder.

Neurosis can be defined as a mild to moderate mental disorder with possible distressing symptoms, but without loss of insight of reality testing. Additionally, there is no apparent organic etiology. Simply stated, a neurosis is an external manifestation of an emotional issue.
Problems with gambling, smoking, sleeping, sitting still, believing you are ill when there is no apparent physiological origins, faking an illness, feeling anxious, etc., are all examples of a neurosis. The entire aforementioned are externally based problems. An important indicator for neurosis is that the individuals who suffer from these mental disorders recognize that what they are experiencing is not normal; they know something is wrong but they are unable to stop the behavior. A psychosis is a serious mental disorder where the individual loses contact with reality. Psychoses may consist of mood swings, delusions or hallucinations, distorted judgment, and inappropriate emotional responses. Simply stated, a psychosis is a mental disorder with an internal manifestation focused in the brain of the individual who is no longer in touch with reality. Examples include Schizophrenia, Psychotic Disorders, Dementia, Alzheimer, and other disorders where the individual does not know that they are not in touch with reality. Remember: most neuroses and psychoses can have their origin in General Medical Conditions and/or Substance-Related Problems. (See, Alternate Diagnostic Possibilities.

All humans-and possibly other animals-suffer from some level of neuroses. Maybe you smoke, drink a little too much alcohol, have a bit of a temper, can’t handle a dirty ashtray, pick your nails, feel sick when you are not really ill, can’t remember what you read, are unable to be intimate with others, etc. All of these are external experiences and defined as neuroses. Many people experience a temporary or transient psychosis. Possibly you have taken some medication-drugs causing you to loose touch with excepted reality-and others report that you were, ‘out of this world’. You may have been so ill that you began hearing voices or sounds and believed they were real. Or, you may have had a traumatic experience that sent you into altered state of consciousness. And there are some who suffer from conditions such as schizophrenia or other psychotic disorders that are more fixed in a psychosis creating a permanent state of being; they live a great deal of their life in a state of psychosis. Those who are neurotic typically know they have a problem. Those who are psychotic have lost touch with reality and therefore do not know that the manifestation is focused in the individual’s mind.

Over the years, as a practicing psychotherapist, author and professor of psychology, I have altered my perception about the true nature and movement of neuroses and psychoses. The current belief is that an individual may be neurotic or psychotic. And, that an individual can move from neurosis to psychosis and back to neurosis. I believe that the aforementioned is true. However, what I have come to understand is that humans—and possibly other animals—spend their entire life fighting the tendency to live in a state of psychoses. Now, I acknowledge from the beginning of this section that there is currently no proof to suggest that my belief is true. Having made that disclaimer, I am offering you some thoughts about the pull that comes in the shift from neuroses to psychoses. However, before I move forward I am going to supply you with a brief understanding of neuroses, psychoses and the fluctuation between the two.

The movement from neuroses to psychoses is fluid. To get to a psychosis state a person must travel through a neurotic state. For some it is a quick shift into a psychotic. For others, it can take a lifetime. And still others may move back and forth from neurosis to psychosis. Let’s focus our attention on Figure A.
Notice that the line starts at zero and ends at six. Please keep in mind that these numbers are arbitrary, intended to supply you with a visual image of the movement and change from a neurosis to a psychosis. The numbers suggest the degree of intensity of the problem; the neurosis or the psychosis. First, focus your attention on the numbers from zero to three and a half. This is the range where most people live their lives. While I don’t believe it is possible to live at the point of zero, it is necessary to start with this point of reference. In any given second, minute, hour, day, week, etc., humans fluctuate in the degree of their neurosis as they move in and out of stress. (A discussion of stress and release will follow.) The range between three and a half and six indicates psychosis. As I suggested earlier, some will cross the line between neurosis and psychosis. But here is where I take the concept a step further.

As we live in our daily neuroses, people work both consciously and unconsciously to stay or keep in touch with reality. This daily battle rules our lives. And, as you can see in Figure A these neurosis/psychosis fluctuate to varying degrees. But some lose the battle with the self. For a variety of reasons, they slip into a psychosis and loose touch with reality. Fighting against this tendency most people will return to a previous state of their neurosis. But, there is the ever-present pull into a state of not having to deal with life’s problem. This state of unaware bliss is the state or condition that most people fight and some lose. Here are a couple of examples.

Mary has just separated from her boyfriend of eleven years. She can’t concentrate, sleep, eat, drive, etc. She describes herself as “a mess”. To ease her pain Mary goes to her doctor to get some medication. She begins taking the medication, but it’s not enough to ease her pain so she starts to drink alcohol. As she over-medicates herself, she slips from her neurosis to her psychosis; she loses touch with reality. Her friends try to reach her but she can’t hear what they have to say. For some reason, however, possibly as simple as the passing of time, she backs away from her drug and alcohol use, shifts into a high state of neurosis, and begins to get in touch herself and the world around her. As more time passes, she begins to live her life in a relatively similar state as she did prior to the separation from her boyfriend. Simply stated, Mary suffered from an Alcohol and Medication Substance-Related Disorder With Psychotic Features. She moved from a neurosis to a psychosis and back to neurosis. She fought the tendency to live in psychosis and won. Let’s try another example.

Bill receives a call that his son has just been run over by a car. Rushing to the hospital he is in a heightened state of emotional stress. He moves closer to a psychosis state but is still in touch with reality. He feels numb and unable to comprehend what has happened to his son. In fact, internally he is denying that the event occurred. Walking into the hospital he is met by the police who inform him that his son is dead. Falling to floor, Bill is taken into the emergency
room. The medical team is unable to communicate with him. Bill stares into space. No treatment brings him back to reality. Here is an example of someone who moves rapidly from neurosis to psychosis and does not return. He lives in a state of non-reality. The trauma, possibly Acute Stress Disorder With Psychotic Features, seemingly caused the neurotic to psychotic shift. Bill was unable to fight the pull into psychosis.

So as you can see, a state of psychosis is a strong pull, one which can affect all humans in their life time. It is the human system under stress that tempts the individual into the ranges suggested in Figure A. But what about the stress? How do we manage and survive under stress? Let’s take a look at the process.

**Stress**

We all live under some level of stress; varying degrees of stress are expected as a normal part of living. Stress comes from an infinite number of areas: work, relationships, money, family, illness, moving, death, weather, climate, etc. While many work hard at avoiding stress or stressful situations, there is no way to completely avoid or dismiss stress from our lives. How we live and deal with stress plays the single most important part in our overall mental health. So what is stress?

Stress is either a psychological and physical strain or tension generated by physical, emotional, social, economic, or occupational circumstances, events, or experiences that are difficult to manage or endure. To survive, we must release the stress. If we do not release the stress, it may manifest itself in a physical or mental health disorder. Therefore, stress management is essential for normal, healthy living. Since we believe that stress exists, we must learn how to manage stress. This management is done through the process of stress release.

As an illustration of the concept of stress and release, Figure B supplies you with a visual image. Focus your attention on Figure B.

Figure B

Stress levels are identified along the left side of Figure B with the symbols, SL. The symbol, SL⁰, represents a stress baseline for an individual; the system under observation. Accordingly, SL⁰ represents a stress level of zero; the individual is not under any self identifiable or noticeable stress. (Note: all systems live under constant stress. Most of the time, it
is not noticeable or the system has adapted to the stress such that it is no longer noticeable.

There are an infinite number of stress levels. Every individual is different with respect to the amount of stress they can live under. For the purpose of this presentation I have separated stress into four levels, $SLO$, $SL^1$, $SL^2$, $SL^3$, with $SLO$ being no stress and $SL^3$ being the highest level of individual stress. The infinite amount of stress exists between the $SLO$ and $SL^1$, $SL^1$ and $SL^2$ and so on.

The curved line represents the rise in stress over time from $SLO$ through $SL^3$. Notice at the peak of each curved line is symbols representing release of the stress; $R^{T-I}$, $R^{T-I}$, $R^{T-I}$ etc. The $R$ is the release, the $T$ is the moment the stress release begins, the $I$ is the period of time it takes to release the stress and bring the individual down to their baseline of stress, $SLO$. Again, keep in mind the level of stress and time it takes to relieve the stress will vary for each individual; everyone will reach a point where they—the system—can no longer live under the stress. Accordingly, the stress must be released or the individual will not be able to sustain themselves at previous stable stress levels.

The time between each stress and release is identified at the bottom of Figure B below the horizontal baseline as $T^1$, $T^2$, $T^3$, etc. As is the case with the levels of stress, elapsed time between the stress and release is infinite. And, the time lapse between $T^1$ and $T^2$, $T^2$ and $T^3$ etc., will vary from one individual to the next. Let’s take an example that most can relate to, the stress and release related to the desire or need to masturbate.

Before I move forward with this example, I acknowledge that discussions about masturbation cause many people to become uncomfortable; embarrassed by their own, personal masturbatory habits. Masturbation is normal. Frequency of masturbation varies between individuals. Using masturbation as a stress release model is an excellent tool to use in explaining stress and release. Allow yourself the opportunity to gain a comprehensive understanding of the stress release concept through the following example.

Over time, Larry begins to feel what he identifies as a sexual tension. (The tension may not be sexual at all, but rather related to a more covert stressor.) As more time passes he feels a greater sense of tension. When he decides he no longer wants to deal, or is capable of dealing with the tension, he masturbates to release the tension.

For some the experience of this type of tension, stress and release, can take place three, four, or more times a day. Therefore, the period of time between $T^1$, $T^2$ and $T^3$ might be a matter of hours. For others, the time between acts of masturbation, stress and release, may be years; one may simply have no desire to masturbate for a year or more if at all. What’s normal? Whatever is normal for that individual. At what level of stress will one individual masturbate verses someone else? Everyone is different; stress release and time vary from one person to the next.

Now you have some concept of stress and release. So how does this apply to mental health? Many believe that all diagnostic presentations are managed through stress and release over time. Let’s look at a few examples.

Mary suffers from a Tic Disorder known as, Tourette’s syndrome. This disorder consists of both body and vocal tics; involuntary body jerks and vocal utterances. As Mary experiences stress, her way of releasing the stress is to tic. Some tic releases may take place over a matter of seconds while other tics may take minutes. Now go back to Figure B. It is impossible to truly identify Mary’s stress level (SL) relative to the stress levels in others. However, identifying the time ($T$) between the elapsed stress releases and amount of time of release ($R^{T-I}$) is quite calculable. Simply stated, Mary’s tics are her vehicle to release her stress. How about a few
more examples?

Ray suffers from a condition known as Pathological Gambling Disorder, part of the group of Impulse-Control Disorders. Like Mary, Ray has a way of releasing his stress. Over some time, let’s say 30 hours, Ray’s body and mind go through varying levels of stress. When he can no longer handle the stress, Ray gambles in an attempt to release his stress. Unlike Mary, Ray’s release time \( (R_{T-I}) \) is much greater. Larry may gamble for hours, days at a time, before he experiences a sense of release. Going back to the act of masturbation, the release defined as an orgasm will take four to ten seconds for most people. In Mary’s case, a tic will last for a fraction of a second. But, for Ray, the stress release could take days.

Laura and Jesse smoke cigarettes. While Laura smokes 30 cigarettes a day, Jesse smokes 10. Using Figure B, can you now envision how Laura and Jesse each manage their stress? The time laps between \( T^1 \) and \( T^2 \), \( T^2 \) and \( T^3 \) etc., for Laura is different from Jesse. Additionally, the length of time Laura and Jesse spend smoking their cigarettes relate to the actual release time \( (R_{T-I}) \).

So why is understanding this concept important. Again, all psychiatric illness is managed through stress and release. Alcohol intake, sleep, depression, anger, etc., are managed through stress and release over time. If the stress is not released, the individuals neurosis becomes more unmanageable. And, if the neurosis is not managed properly, the individual may move into psychosis because they are no longer able to deal with the reality and inability to relieve the stress. Ultimately, they may descend or slip into a psychosis as a way to avoid dealing with an unmanageable level of stress. So, if you now look at Figure A you can envision that the fluid movement of neuroses and psychoses is managed through the process of stress and release over time.

Remember the separate cases of Mary and Bill. Mary managed her stress with medication and alcohol. When she consumed too much alcohol, she shifted from neurosis to psychosis. In time, she shifted back to neurosis. Bill was unable to release the stress related to the trauma of losing his child. He rapidly shifted from neurosis to psychosis and was unable to return to his previous state of functioning If you can keep this concept in mind you will be able to comprehend the next section; function and dysfunction.

**Function and Dysfunction**

Over the years, the use of the terms function and dysfunction as they relate to the human condition has become cliché. Originally, malfunction was used to describe a system (individual or group) that was not functioning in a normal or healthy manner. (There’s that word again, normal.) Dysfunction took the place of malfunction. Now, used primarily in pop psychology circles, the use of the term Dysfunctional Behavior has watered down the true understanding and meaning of function and dysfunction. In this section I will attempt to bring together the concepts and meanings of function and dysfunction as they may relate to normal and abnormal behavior and neuroses and psychoses. Let’s do a quick overview.

You have leaned that the relation between normal and abnormal is fluid. All human conditions can shift from normal to abnormal rapidly or over a long period of time. Additionally, identifying normal and abnormal must encompass a cultural definition and the impact on the individual such that it may cause impairment in their life or the lives of those around them; work, school, social, and interpersonal relationships.

You have also learned the difference between neuroses and psychoses. And, like normal and abnormal, neuroses and psychoses are volatile and fluid over time. An individual may shift
from a neurosis to a psychosis and may return to a neurosis state depending upon the condition of the individual. Also, should an individual reach psychosis, they will no longer be in touch with reality. Now, having recapped those two important areas, let’s see how function and dysfunction work in relation to the individual and those around the individual.

At this point in *A Psychiatric Diagnostic Primer*, I am introducing Figures C through F. Each of the figures will assist and encourage you to capture the concepts and meanings that embrace function and dysfunction. Let’s start with Figure C.

Figure C

![Function Scale](image)

Figure C consists of a horizontal line. The line is divided in the middle by a zero. To the left and right of the zero, you will notice the numbers one to ten. To the right of the zero, you will see numbers that are marked by a positive sign; to the left of the zero are numbers that are marked by a negative sign. The concept of positive and negative are used to show direction, not better or worse. That is, a +3 is no better or worse than a -3.

Figure D

![Function Scale: From Function to Dysfunction](image)

The number only relates to the number before or after indicating more or less function or
dysfunction. The further one moves away from 0 towards + or - 10 the more intense the level of
dysfunction the individual experiences in their life. Keep in mind that the space between each
number should be viewed as infinitely divided. However, for the purpose of this presentation the
line is only divided into 20 equal parts; -1 through 10 and +1 through 10. Now I would like you
to turn your attention to Figure D.

Using Figure C I have added a circle to Figure D. The circle is located equally between
+4 and +5 to the right (+4.5) and -4 and -5 (+4.5) to the left. Using this image you can now
bring the concept of function and dysfunction to a visual level. It is critically important to realize
that the placement of the circle in the line is arbitrary; there is no significance to the placement
other than for the purpose of this presentation. You certainly do not want to go around telling
your friends that you are a +2 or -3 as if those numbers meant something outside of the context
of this example.

Notice that inside of the circle I have introduced Function. Outside the circle I have
introduced Dysfunction located above the line on either side of the circle. This suggests the
following: when an individual is experiencing functionality, they are between -4.5 and +4.5;
when they are experiencing dysfunction they are between -4.5 and -10 and +4.5 and +10, or
within the circle. This is similar to the concepts of normal and abnormal. The significant
difference is that normal and abnormal usually relate to the condition or status of the entire
individual’s mental status where function and dysfunction relate to the component part(s) of the
mental status of the individual. Similarly, neuroses and psychoses differ from function and
dysfunction because once an individual reaches a psychosis they are no longer living in reality.
All three concepts are easy to confuse and may be difficult to separate. For the purpose of this
illustration, I am going to use myself as an example.

At the time of the writing of this book, I suffer from three individual, separate
#diagnosable psychiatric disorders. The first is an Eating Disorder known as Binge/Eating
Disorder. In my case, I am out of the expected normal range of weight for my height but I am
not psychotic. In this area, I am dysfunctional with a specific psychiatric condition; outside the
normal standard of weight for my culture. But, that does not mean that I am unable to function in
the real world. Second, I suffer from an Impulse-Control Disorder known an Onychotillomania; I
tend to bite and pick on my fingernails and the skin around the cuticle. So, in this area of my life
I am dysfunctional with a specific psychiatric condition; outside the normal standard of behavior,
but I am not psychotic. Again, that does not mean that I am unable to function in the real world.
Finally, I suffer from Wittmaak-Ekbom’s Syndrome more commonly known as, Restless Leg
Syndrome (RLS). I am dysfunctional in this area of my life because I am unable to stop moving
my legs while lying in bed. Again, I am dysfunctional with a specific psychiatric condition;
outside the normal standard of behavior, but I am not psychotic. Each disorder is an example of
my neuroses coming to the surface. Remember, we all live and survive with our neuroses until
we are pulled and remain in a psychosis or we resolve the emotional reason that is the
underlying cause for the neuroses.

So does the list of aforementioned psychiatric conditions mean that I am unable to live
my live in a relatively normal manner? The operative term here is, relatively. In all other areas
of my life I am functional. I don’t see visions, I can read and write, I do not suffer from Mood
Disorders, I don’t drink alcohol or use drugs to an uncontrollable excess, etc. It is only in the
three aforementioned psychiatric areas that I am considered not normal; abnormal. But, this does
not mean that I cannot live my life in a generally functional fashion.

Remember our discussion about normal and abnormal? Each of us is normal and
abnormal in some areas of our lives. We all have psychopathology. Therefore, each of us experiences levels of function and dysfunction in specific areas of our lives. Let’s see how this works by observing Figure E.

Figure E

In Figure E I have added a series of additional circles. These circles are identified as ‘a’ through ‘e’. Remember, there could be an infinite number of circles with an infinite number of identifications. This Figure suggests that individuals live and survive at different levels of function and dysfunction. But, these levels are not fixed, they are flexible and fluid moving from level to level depending on a wide variety of factors such as work, play, school, environment, finances, relationships, sleep, substances, etc. Figure F brings the entire concept into full perspective.

Figure F supplies you with a more realistic image of function and dysfunction. A concentric circle is not an optimal presentation of our fluid functional and dysfunctional lives. Additionally, Figure F needs to be viewed as a three dimensional image, similar to a ball. If you envision the ball cut in half you would see something similar to Figure F. It is with that perspective that you will have a complete image of the function/dysfunction paradigm.
Individuals are not static, rather individuals tend to move from one level of functioning to the next, in and out, back and forth, up and down, on a fluid, moveable basis. It is our level of function and dysfunction that defines who we are relative to others in the world. Therefore, I suggest the following. All of us are attracted to people who are at the same level of function and dysfunction as we are. In essence, we are attracted or repelled by each other's neuroses. Additionally, I would suggest that someone on functional level ‘a’ would not be attracted or want to be with someone on a function and dysfunction level ‘d’. You simply would not blend well with their level of functioning or dysfunctioning. Whether they are better or worse by degree, you would not get along with them. Conversely, a person functioning at a higher level of dysfunction ‘e’ would not get along with a person at a lower level of function ‘b’. Let’s try a few examples.

Matthew has been invited on a blind date. He is immediately attracted to Sharon’s looks; he likes what he sees. Having a discussion over dinner, Sharon starts ordering one Martini after another. In a short time, Sharon is drunk. Matthew asks Sharon, “Do you drink like this all the time?” Sharon loses her temper. “You’re just like my last boyfriend, counting every drink.” Matthew looks forward to the end of the evening. Sharon’s level of functioning is not consistent with Matthew’s.

The next night Matthew is out with some friends. He is suddenly distracted by a woman who walks into the room. Matthew lights a cigarette, gathers his courage and walks up to the women. When she sees the cigarette in his hand she says, “I’m not interested in having people in my life who smoke.” Walking to the other side of the room, the young woman sits next to a man in a business suite. “My name is Ann”, she says to the man next to her. “Sean, good to meet you.” As the evening goes on, Ann and Sean seem to enjoy each other’s company. By the end of the night they decide to go back to Ann’s house. Walking in to her home, Sean immediately notices that the house is a mess; dirty from top to bottom. Sean is turned off by the look of the house and decides to cut the evening short.

Now, while these examples may seem silly, the truth is we are all attracted or repelled by each other’s levels of functioning and dysfunctioning, or idiosyncrasies. And, as soon as we find someone in our range of functioning or dysfunction we have the opportunity to enter into some level of a relationship.
Now that you have some rules and guidelines, let's return to the primary content of this text, psychiatric presentation and diagnosis. To make a proper diagnosis we must follow guidelines to get to the point of making or denying a diagnosis by using signs and symptoms.

**Signs and Symptoms = Syndromes**

To make an effective and proper diagnosis you must have both signs and symptoms. It is very difficult and risky to make a diagnosis without these two important components. Yet, people come to conclusions on a regular base given one without the other.

For example, you are driving down the street. You look to your left and sitting under a bridge is a man. He is wearing a long, dirty overcoat. In his right hand is a brown bag with a bottle sticking out of the top of the bag. He must be a...? I’ll bet you said alcoholic, bum or both. Yet, you came to that conclusion through observation only. That is: you observed only the signs.

While driving through a downtown area you observe a woman. She is wearing a leather mini skirt, halter top, stiletto high heel shoes. Her face make up is very heavy and dark. She must be a...? My guess is that you said hooker or prostitute. Why did you come to that conclusion? Simply because of what you observed? Don’t you need more information before you can move to such a conclusion? Would you want your attending physician to rush you into surgery because you tell him you have the symptoms of a stomach ache?

Your son is rushed into the emergency room. He is unconscious. Should the surgeon begin operating without observing the signs and learning what the symptoms were before your son fainted? This makes for good, reasonable science and medical practice.

The year is 1692 and the following is reported to you by someone: Last night I saw a woman in the forest, sitting in front of an open fire, petting a black cat and wearing a black robe under a full moon at midnight. Today, little Johnny broke his leg. The woman must be a...? Did you say witch? Well, a lot of people came to the same conclusion back then. And because of their conclusion, 20 people were put to death because they were believed to be witches; 19 were hanged and one was suffocated by placing rocks on his chest until he could no longer breath. Ah yes, there is nothing like observation to lead us to a solid, rational conclusion.

To come to a conclusion in psychiatry you must have both signs and symptoms. A young woman comes to you for help. The following signs are observed; her eyes are watering and she appears exhausted. She is sniffling. She is holding her head. Given these observations there are many diagnostic possibilities; allergies, food poisoning, brain tumor, sleep deprivation, substance use, she just broke up with her significant other, her mother just died, etc. So what’s the diagnosis? There is no diagnosis until we learn the symptoms.

The symptoms are reported by the individual under observations. (Sometimes this may not be possible if the individual is not awake, incoherent or is unable to communicate because they are too young or their language in understandable.) So now you ask your young patient: Can you tell me what you are feeling? Did anything happen to bring out what I am seeing and what you are feeling? And she reports: I have a stomachache, I haven’t slept; I haven’t eaten for three days and I feel like I want to die. Then she says; I just broke up with my boyfriend. We’ve been together for six years. I am so depressed. Can we come to a reasonable diagnosis? Within bounds we can. However, you must still look at the possibility of physiological problems and substance problems. Once you have ruled out these possible diagnostic areas you may choose to move to an initial diagnoses: possible Mood Disorder. Note, I said possible. That is because there may be other factors that have not been ruled out. Even with diagnosis of a Mood Disorder
some might say it is really Bereavement. That is, the separation from a significant other is similar to a death.

It is the process of ruling out possible diagnoses that will lead you to a reasonable diagnostic conclusion. So, your last rule is: Observe the signs and ask for the symptoms. Then and only then may you move to a diagnosis. Stated another way: The pathology—the individual signs and symptoms—allow you to move to a syndrome. A syndrome can also be described as disease, morbidity and diagnosis. These words are all interchangeable and lead to the same communicative outcome.

Now, let’s move into the body of *A Psychiatric Diagnosis Primer*. But, before we do I want to re-establish a previously stated point: We all have something. No one gets out of this world free of disease. Most of us have a little part of what makes a disorder. Eventually, at some time in your life, you will exhibit some psychiatric pathology. I am reinforcing this idea because it is the plague of every psychology student to take on the psychiatric disorders that they are studying. This process can be, for some, crippling. Medical Student Syndrome may even prevent some students from living relatively normal, functional lives. Remember: To have an individual diagnosis you must meet the criteria for that diagnosis. Getting drunk does not give you an Alcohol-Related Disorder. Not being able to have an orgasm does not give you a Sexual Disorder. Losing your temper does not give you an Impulse-Control Disorder. DO NOT READ INTO EVERY DISORDER AND THINK YOU’VE GOT IT! Now, let’s take a look inside, *A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness.*
What You Will Find in This Book

Starting with this introduction you will find a complete list and explanation of psychiatric diagnoses, ending with a useful series of helpful indexes. You will be able to easily maneuver your way through these previously complicated areas of medicine and the discipline of psychiatry. Take a few moments to read through the following sections that explain how to read and use *A Psychiatric Diagnosis Primer: an easy guide to identifying psychiatric illness*.

Case Study

Most books do not contain a breakdown of diagnostic categories with diagnosis along with a case study. *A Psychiatric Diagnosis Primer* includes both of these areas. The purpose of the case study is to help you link various diagnoses to an individual’s presentation and presenting problems. However, this case study is different.

The case study of SamanthaLynn is treated as one presenting case problem, followed by every diagnosis in *A Psychiatric Diagnosis Primer*. The goal behind this approach is to help you place your attention on all the individual diagnostic areas without the variations that may exist in a patient’s presenting problems. By taking this approach I have narrowed down the length of a case study book to a more manageable level.

Diagnosis

The Diagnosis section of *A Psychiatric Diagnosis Primer* is the true body of the book. One of the complications in writing *A Psychiatric Diagnosis Primer* was condensing pages and pages of psychiatric documentation down to a single page that is easy to understand and use. In fact, for many years it was that problem that was the major roadblock that stopped me from writing this book. But now, I have solved the problem.

Each diagnosis has been narrowed to one page. A single page contains all the information you need to understand the important concepts of the diagnosis, including cross references to other diagnoses.

Starting on page 99 you will find the Name of the disorder, Code for the disorder and Group in which the disorder resides in a larger category. Following the heading you will find the Behavioral Presentation, Specifiers, Codes and Comments, Degree of Impairment, Suggested Course of Action, Psychopharmacology, Alternate Diagnostic Problems, and Internet Resources. Let’s take an in depth look at each page, section by section.

Disorder/Code/Group

This section is separated into three separate subsections; Disorder, Code and Group as follow:

Disorder:

The disorder appears at the top, center of each page. The disorder is the technical name of a psychiatric disorder. The name of the disorder has been adapted by the psychiatric medical community as a heading, descriptor or mnemonic tool to describe an individual mental health disorder/syndrome/disease/morbidity/condition. For the purpose of brevity, the word, “disorder”, has been dropped from the technical name descriptor. Therefore, when you see a condition such as, Hypomanic or Histrionic Personality, you simply complete the technical name by
adding the word, disorder, such as, Hypomanic Disorder, Histrionic Personality Disorder, etc. Where the word, syndrome is required, syndrome is included to help you identify the correct name for the disorder such as, William’s Syndrome or Restless Leg Syndrome.

**Code:**

Code appears on the left side of each page below the Disorder. The code is an numerical shorthand that is correlated to an individual disorder. This code is used by both diagnosticians and insurance companies. The code number is technically known as the International Classification of Diseases (ICD) in ongoing editions; 7, 8, 9, 10 and so on. The ICD is the international standard diagnostic classification for all general epidemiological and many health management purposes including insurance billing and the analysis of the general health situation of population groups and the monitoring of the incidence and prevalence of diseases and other health problems. This analysis may be in relation to other variables such as the characteristics and circumstances of the individuals affected. Additionally, the ICD is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and hospital records. The ICD coding system is updated from time to time to cover all medical diagnoses and conditions. When documenting a disorder it may be necessary, depending on the organization or environment, to include the code number. See: The Multiaxil Assessment example to gain a greater understanding of this documenting procedure.

**Category:**

The Group appears on the right side of each page below the Disorder. All individual diagnostic conditions are part of a larger major descriptive group or category. These major groups are the umbrella for the subcategories; the individual diagnoses. I have inserted a page number after each diagnostic group. You may elect to go to the major group to view the entire list of disorders in that group.

**Behavioral Presentation**

The Behavioral Presentation section appears along the left side of each diagnoses page. The section will be an essential focus of your interest when looking up and identifying psychiatric disorders. For most people it is the Behavioral Presentation section that is the primary reason that they are investigating the various presenting mental health problems of an individual.

In the Behavioral Presentation section you will find the primary characteristics that make up an individual diagnosis. The characteristics are divided by the icon symbol, ‘ ‘, shown in a row on the left side of each page directly below the Behavior Presentation. In most cases there is
a series of single words or statements that make up the characteristics of the individual disorder under investigation. You will notice the statements are brief and blunt. For the most part they are a series of facts. To economize space the statements are often incomplete sentences intended to get directly to the point.

NOTE: You may assume that most diagnoses also consist of the following:

- Symptoms cause clinically important distress or impairment in work, school, social or personal functioning.

To circumvent the insertion of this repetitive statement and in the economy of space, I have taken the position that you will include this information as part of your understanding of any diagnosis under investigation.

Occasionally you will find phrases such as: ‘Two or more of the following may occur within a few hours to several days’. Or, ‘Seven or more of the following occur’. These are specific behaviors and characteristics related to an individual diagnosis or the number of characteristics that must exist for the individual to receive the diagnosis. On rare occasions you will find as many as five icon symbols. This number is required to truly delineate an individual diagnostic presentation. In some cases I have supplied a cross reference page number to assist you in gaining a complete understanding of the behavioral presentation.

It is important that you follow the guidelines for making an individual diagnosis. These guidelines were created as a result of investigative work to assist medical professionals with minimizing a possible incorrect diagnosis of an individual’s mental health presentation. Remember, when you are given a diagnosis with a specific minimum of presentations it is important to follow the minimum guidelines.

Keep in mind that it may be difficult to identify all the necessary characteristics for an individual to receive a specific diagnosis. In fact, most individuals will not meet #the criteria for a specific diagnosis. As is often the case, each diagnostic category has a separate diagnosis known as, Not Otherwise Specified. Not Otherwise Specified gives you the latitude to get as close to meeting the criteria of a specific diagnosis as possible. This allows a diagnosis to be made within a major group that does not meet all the criteria for a more specific diagnosis, but does meet most of the categorical criteria. For instance, under the general category of Anxiety Disorder exists a specific disorder referred to as, Acute Stress Disorder. If not all the criteria are met for Acute Stress Disorder, but you feel that the presentation of the individual still belongs in the Anxiety Disorder category, you may use Anxiety Disorder Not Otherwise Specified.

**Specifiers, Codes, and Comments**

You will find the Specifiers, Codes and Comments section directly below the Behavioral Presentations. This section is provided to supply you with supplemental information to the Behavioral Presentations. Some of the information in this section will be of the nature of general interest and education about the diagnosis under investigation. The information is identified with four separate icons as follows.

- This type of information is identified with the icon, ‘’. When giving a diagnosis or identifying a specific problem the field of psychiatry suggests the use of specifiers. These specifiers help you classify the diagnosis into a very
specific subgroup beyond the individual diagnosis and assist in communicating the mental health problem to others. For example, if you believe the individual you are attempting to diagnosis suffers from Phencyclidine Dependence you may also further identify the diagnosis Phencyclidine Dependence with Physiological Dependence. Phencyclidine Dependence is part of the subgroup of Phencyclidine Use Disorders which is of the general category of Substance-Related Disorders. Premature Ejaculation Disorder, a subgroup of Orgasmic Disorders under the general category of Sexual and Gender Identity Disorders may be made further specified as follows, Premature Ejaculation Disorder, Lifelong Type. Vascular Dementia, part of the Dementia subgroup which is part of the general category of Delirium, Dementia, and Amnestic and Other Cognitive Disorders may be extended with specifiers such as, With Delusions or With Depressed Mood or With Delirium, to name a few.

This type of information is identified with the icon, ‘‘. Here you will be able to identify specific information about the subgroups and categories of the disorder under question. In some cases you may receive information about a disorder’s previous name. For instance: ‘Circadian Rhythm Sleep Disorder is part of the subgroup of Dyssomnias. And, ‘Circadian Rhythm Sleep Disorder was formerly known as, Sleep-Wake Schedule Disorders’.

This type of information is identified with icon, ‘‘. This section consists of statistics, descriptive information and general data. For example: ‘Studies suggest that approximately 2% of the general population, 10% of the outpatient mental health patients, and 20% of psychiatric inpatients may suffer from Borderline Personality Disorder’. Or, ‘A tic is a motor movement or vocalization that is non-rhythmic, rapid, repeated, stereotyped, or sudden’. Or, ‘Cocaine is also known as Blow, Crack and White Angel’.

This type of information is identified with icon, ‘‘. In some cases I have supplied you with the word origin (etiology) of an individual diagnosis. For instance, Bipolar I Disorder: From Latin – *bis*, twice + *polaris*, of or relating to a pole, *polus*, a pole.
Finally, each diagnosis consists of varying amounts of information. In some instances there is very little additional information; in other instances there is a great deal of additional information about the diagnosis.

**Degree of Impairment**

Degree of Impairment is located on the left side just below Specifiers, Codes and Comments. This section supplies you with the range of projected impairment that may be expected from a particular diagnosis. The impairments are divided into six separate categories: Very Mild, Mild, Mild to Moderate, Moderate, Moderate to Severe and Severe. Each of the six possible impairments has an individual icon box, ‘ ‘. The projected level of impairment has a box with an ‘x’. Only one box out of the six will contain an ‘x’.

Understand that most diagnosis could have every box marked with an ‘x’. This is because everyone deals with their mental health disorder at varying degrees of severity. That is, some people respond to a problem in different ways. For example, someone who suffers from a sleep disorder with a box marked, Mild to Moderate, may be so impaired that the condition leads to their death. Should this individual’s condition have been considered, Severe? How can it happen that the individual ends up dying as a result of their disorder? In this case, as a result of their sleep deprivation their condition may, ultimately lead to an ineffective decision while driving a motor vehicle that in turn leads to an accident, their death and possibly the death of others. In fact, driving sleep impaired may have the same end result as driving under the influence of a mind altering substance, driving while in a rage, etc. Many similar examples can be used when evaluating Mild to Severe mental health problems.

Sexual Dysfunction, while not life threatening, may lead to depression that ultimately leads to suicide. The Sexual Dysfunction may be noted as Mild but the impact of the dysfunction may be, Severe. While this is not true in all case it may be true in some cases. Therefore, understand that the decision to mark, Mild through Severe is based on the overall expected level of severity of a particular condition within the general population of people who may suffer from the identified disorder. However, you must make a case by case decision when dealing with severity ratings and diagnosis.

**Suggested Course of Action**

Suggested Course of Action helps you decide on a possible course of treatment to take for the individual mental health diagnosis. The Course of Action Section is divided into six separate categories: Medical Attention, Therapy/Counseling, Support Group, Special Needs, Change of Location, and Time Off. Each of the six possible courses of action are separated with an icon box, ‘ ‘. Unlike the section, Degree of Impairment, the Suggested Course of Action may have more than one icon, ‘ ‘, with an ‘x’ in the box. This suggests that multiple courses of action may be taken given an individual’s presentation.

It is important to note the Suggested Course of Action is based on a general consensus of treatment approaches given a particular psychiatric presentation. It is, however, by no means the only course of action you might take in a given case. For instance, when dealing with a Substance-Related Disorder, a change in location for the substance abuser may or may not be the best course of action. If an individual has strong ties to a location, family, friends, work, school, etc., changing locations may be more exacerbating and stress inducing to the condition than seeking treatment. However, in other cases it may be more helpful for the individual to seek in-patient treatment in another location outside of their home area and they may benefit from
returning to their home for additional detoxification and therapy.

An individual who is suffering bereavement may or may not need medication for depression; may or may not need time off from work; may or may not need a support group. Clearly, there is no simple solution and fixed template in this area of treatment; each case must be individually evaluated. As I have indicated previously, psychiatry is not an exact science. It has few if any fixed rules, directives or predictable outcomes.

Finally, there are a number of types of therapy. Some of those are: Adlerian Therapy, Behavior Therapy, Existential Therapy, Gestalt Therapy, Person-centered Therapy, Psychoanalytic, Rational-emotive Therapy, Cognitive-behavioral Therapy, Reality Therapy, and Transaction Therapy. To assist you in understanding these therapies refer to: http://www.psyweb.com/Mdisord/MdisordADV/AdvPsych.jsp

Psychopharmacology

The substances listed under the Psychopharmacology section are not suggested medications. Rather, it is my goal to supply you with a relatively comprehensive list of generic and brand name substances that may be used to treat a particular psychiatric illness. You should understand that I am in no way supporting the use of a particular medication, either generic or brand named, nor am I directing you to take the medications listed in this section. All medications should be prescribed by a physician who is trained in the treatment of the presenting diagnosis. There are three options listed under Psychopharmacology: Medications, Natural Substances and None Suggested. Each of the options are identified with a icon box, ‘ ’. The Psychopharmacology section may have one, both or no suggestions offered as indicted with an ‘x’ in the icon box. Additionally, I have supplied you with a page referral which lists most of the substances that may be used for treatment intervention.

Alternate Diagnostic Problems

Most diagnoses have what are known in psychiatry as a Differential Diagnosis. So what does this mean? Whenever a diagnosis is suspected it is important to consider all other possibilities; the alternate diagnoses. You must ask the question: What other psychiatric diagnoses might the individual receive given the presenting signs and symptoms?

Many diagnostic categories consist of presentations that may, in fact, appear in another diagnosis. For instance, someone who is suspected of suffering from schizophrenia may have General Medical Condition(s), Substance-Related Disorders, Separation Anxiety, Mood Disorders, and other possible diagnoses. It is imperative that in the process of making a correct, final diagnosis all diagnostic possibilities be examined. Let’s take a look at a diagnosis that some clinicians believe is over diagnosed in the field of psychiatry.

Attention Deficit/Hyperactivity Disorder is referred to by some as, The Diagnosis De jour. This means that the diagnosis of Attention Deficit/Hyperactivity Disorder is the popular diagnosis of the day for both children and adults. Post Traumatic Stress Disorder has the same reputation for being over diagnosed. But the reality is that Attention Deficit/Hyperactivity Disorder has many of the symptoms of Mood Disorders. Accordingly, children and adults who are suspected of suffering from Attention Deficit/Hyperactivity Disorder may in fact be suffering from a Mood Disorder or Substance-Related Mood Disorders. It is imperative that we do not jump to conclusions when making a diagnosis; all possible diagnoses must be ruled out before making a final diagnosis. Additionally, most individuals suffer from more than one diagnosis. In fact, it is uncommon for someone to be diagnosed with a single, isolated psychiatric problem.
or diagnosis. If an individual is diagnosed with more than one diagnosis the process is referred to as a Dual Diagnoses or Co-Morbidity.

**NOTE:** Most mental health disorders can be a result of a General Medical Condition or Substance-Related Disorder. Whenever making a mental health evaluation you should always first rule out a General Medical Condition and second, rule out a substance use cause for the presenting problem. Once these two categories have been eliminated as a possibility you should then proceed to any other possible diagnostic category. Therefore, in the economy of informational presentation in the Alternate Diagnostic Problems section, I did not include references to General Medical Conditions or Substance-Related Disorders because they would appear in every alternate diagnostic category. **AGAIN:**

| FIRST, ALWAYS HAVE A MEDICAL SPECIALIST RULE OUT A POSSIBLE GENERAL MEDICAL CONDITION AS A POSSIBLE CAUSE OF THE BEHAVIOR OR CONDITION BEFORE PROCEEDING TO THE NEXT LEVEL OF INDIVIDUAL EVALUATION OR TREATMENT APPROACH. SECOND, AFTER RULING OUT A GENERAL MEDICAL CONDITION, EVALUATE THE INDIVIDUAL TO LEARN IF THEY ARE EXPERIENCING A SUBSTANCE-RELATED PROBLEM BEFORE PROCEEDING TO THE NEXT LEVEL OF INDIVIDUAL EVALUATION OR TREATMENT APPROACH. THIRD, HAVING RULED OUT A GENERAL MEDICAL CONDITION OR A SUBSTANCE-RELATED DISORDER, MOVE TO ALL THE OTHER POSSIBLE DIAGNOSES IN A GIVEN DIAGNOSTIC CATEGORY. |

**Internet Resources**

It is the Internet Resources portion of the book that you may realize is your most valuable tool with respect to being educated and gaining an understanding of an individual diagnostic presentation. Here I supply you with up to four Web Site destinations per diagnosis to help you with your knowledge building (epistemology) as it relates to the disorder under investigation. Once you have arrived at a suggested Web Site you have an opportunity to learn, in detail, about an individual disorder. Additionally, you will have the option of looking at other Internet Resources related to the disorder and other disorders of interest once you have arrived at the suggested Web Site.

Many Internet Resources are sponsored by companies that are attempting to market and sell you their products. This is also true of some of the Internet Resources I have suggested. Note: I am in no way suggesting you buy or use any of the products advertised on these sites. To avoid any conflict of interest I have refrained from any and all support or sponsorship from those who advertise on these sites.

Next, I have attempted to supply you with a wide range of Internet Resources throughout the book. This is not to say that they are the best or only Internet Resources on the subject of the individual diagnosis. The sites are, in some cases, simply adequate. However, the combination of all the Internet Resources offered for an individual diagnosis will give you an excellent resource for researching the diagnosis under investigation. The Internet Resources I have suggested are simply the tip of the iceberg leading to the knowledge that is available about the disorder. Internet Resources containing a wide variety of information are being added to the
internet on a daily basis. Take the time to move beyond my Web Site suggestions. Learn as much as you can about all of the diagnoses offered in my book.

Finally, you should recognize that the sites I have suggested are not scientific in nature. They are simply a general overview of the various presenting disorders. For scientific information about the disorder under investigation you will need to sign on to databases that have scientific journal articles and periodicals. The reason I have not supplied you with those listings is that access to these sites is often restricted, requiring you to be a student or professional to gain access. You may want to go to your local library and ask for access to the various scientific databases such as Medline, Expanded Academic, Ebsco Host, Proquest, and others. As of 2005 Google has added a Scholarly search engine. The information on the scholarly sites may assist in acquiring specific scientific answers to your questions.

Diagnostic Categories
The index of Disorders by Category contains every separate group category and subcategory of psychiatric disorders listed in the *A Psychiatric Diagnostic Primer*. You may turn to this section to acquire an overview about the disorders listed in each group. One of the unique inclusions in my book is listings of disorders and syndromes heretofore not listed in other psychiatric manuals. The purpose behind supplying you with these additional listing is to insure that you obtain comprehensive information about similar disorders in a group category. (See Additional Disorders to follow.) A disorder by Category is divided into four subsections as follows:

General Characteristics:
General Characteristics offers an overview of the psychiatric presentations that weave their way through each disorder in the category. You may want to read this section when you are investigating a particular diagnosis. By reading through every diagnosis you may gain the opportunity to find other diagnoses that are similar to the one you are investigating.

Disorders:
Disorders offer you a complete list of disorders in a specified category. Additionally, I have included the page number of each individual diagnosis within the category. Once you have located the diagnosis you may wish to further investigate simply by turning to the page noted next to the disorder.

Internet Resources
Much like the Internet Resources at the end of each individual diagnosis page, these Internet Resources introduce you to information about the overall group of diagnostic presentations. These Internet Resources will assist you in acquiring a greater understanding about each diagnostic group.
Movies Suggestions:
I believe the Movie Suggestions represents one of the most unique sections of *A Psychiatric Diagnostic Primer*. The movies listed in this section offer presentations of individual disorders or groups of disorders. It is important to keep in mind that in many cases only a portion of the movie offers the diagnostic presentation of the disorders in a group. For example, in the movie, *The Sixth Sense*, less than one minute of the entire movie supplies the viewer with a presentation of a disorder known as Factitious Disorder by Proxy, a subcategory of Factitious Disorders, sometimes referred to as Munchausen by Proxy. In *Along Came Polly* you will find a 30 second section of a Somatoform Disorder known as, La Belle Indifférence. In *When a Man Loves a Woman*, a number of scenes throughout the movie deal not only with the presentations of the Alcohol-Related Disorders, Alcohol Intoxication, Dependence, Abuse and Withdrawal, but the movie also includes presentations of a treatment model used in dealing with substance related recovery known as Alcoholics Anonymous. You will also find instances of Physical Abuse of a Child, part of the group, Other Conditions That May Be a Focus of Clinical Attention. Many family related issues and problems are presented in the movies. Whenever possible I have included documentaries, videos and DVD listings of educational films that have been made dealing with a wide variety of psychiatric issues. (For additional reference you may want to look at my other books on the subject of Cinematherapy™, The Motion Picture Prescription, Reel Therapy™, and Cinemaparenting™.)

Additional Disorders

Additional Disorders is another section of *A Diagnostic Psychiatric Primer* that has previously been omitted from most books on the subject of psychiatric diagnosis. In the process of writing my book I found many other possible diagnoses that were simply too important to exclude when investigating a mental health problem. Having a comprehensive list of disorders is paramount when attempting to identify an individual disorder. Here is an example of what you can expect to find in this section.

Under the general category of Anxiety Disorders you would typically find disorders such as, Acute Stress Disorder, Generalized Anxiety Disorder, Posttraumatic Stress Disorder, etc. These disorders represent the group of disorders currently listed in most diagnostic reference books and manuals. For your reference I have included Hyperekplexia, Hoarding Disorder, and Kok Disease, to name a few. This extends the general category of Anxiety Disorders to encompass a more comprehensive list of potential mental health issues. However, you will not find these disorders in the body of the book. These disorders and many other disorders are listed under Additional Disorders. Unlike the disorders in the body of the book, the Additional Disorders section presents a basic definition of the disorder. For further information on a disorder you may want to execute a search on the individual disorder of interest.
Culture-Bound (Disorders) Syndromes

Previously in *A Diagnostic Psychiatric Primer* I introduced a concept related to cultural awareness in identifying normal verses abnormal behavior. In Culturally Bound Disorders I offer a listing of specific disorders related to a wide range of world cultures. I cannot put a strong enough emphasis on taking culture into account when practicing any form of mental health assessment or treatment. Comprehending individual or group cultural beliefs will afford potential mental health recipients the personal attention they deserve and require.

Multiaxial Assessment

Some diagnosticians apply a Multiaxial Assessment approach to documenting an individual’s psychiatric presentations. This Multiaxial Assessment approach facilitates working with individual psychiatric presentation more manageable and systematic, especially when attempting to communicate with other mental health professionals, treatment centers and insurance providers.

The Multiaxial Assessment approach is separated into five individual multiaxial groups: Axis I–Clinical Disorders, Axis II–Personality Disorders and Mental Retardation, Axis III–General Medical Conditions, Axis IV–Psychosocial and Environmental Problems, and Axis V–Global Assessment of Functioning.

Terms and Concepts

*A Psychiatric Diagnosis Primer* has one glossary, six reference sections, and one index to assist you in gaining a better understanding of psychiatric disorders. The reference sections offer substantial information in the process of cross referencing, understanding and working with the individual diagnoses and diagnostic categories.

Glossary

The Glossary of Terms consists of words to assist you in interrupting and understanding complex psychiatric terms and concepts. The glossary represents an abbreviated list of the most fundamental mental health terms. Use the glossary as a foundation for leaning new words and ideas in the area of psychiatry. To find additional definitions turn to The Dictionary of Psychology. The Dictionary of Psychology is available through Medical Dictionary or Medical Encyclopedia via MEDLINE, an online resource. You also may want to consult Oxford Reference Online, a resource that was a major contributor to *A Psychiatric Diagnostic Primary*. Note: access to these resources may require that you be a subscriber. Many public libraries have access to these sites.

Drugs - Street Names

Mental health professionals use specific diagnostic names for substances that may be abused and might have alternate street names. The substances may be legal or illegal, prescribed or non-prescription medications. Gaining an understanding of the Drugs- Street Name’s list will assist you in being educated about those street names and enable you to communicate with others.
about the individual substances. Ultimately, you can identify the diagnostic categories of those substances.

**Phobias**

Phobias are part of the group of Anxiety Disorders. There are over 550 different Phobias in the Phobias’ list. This section of *A Diagnosis Psychiatric Primer* may enlighten you with respect to the wide range of Phobias that may be present in the human condition. The phobias are listed alphabetically. This is followed by a listing of phobias by their fear. Therefore you may look up the phobia or the problem.

**Manias**

Manias are part of the group of Impulse-Control Disorders. There are over 145 different Manias in the Manias’ list. This section of *A Diagnosis Psychiatric Primer* may enlighten you with respect to the wide range of Manias that may be present in the human condition. The manias are listed alphabetically. This is followed by a listing of manias by behavior. Therefore you may look up the mania or the behavior.

**Pharmaceuticals and Natural Medications**

Medications are typically presented in books such as the Physician’s Desk Reference (PDR) and manuals containing medication listings for the treatment of specific disorders. I decided to introduce this list into *A Diagnostic Psychiatric Primer* in an attempt to educate you about the range of psychopharmacological interventions available in the field of mental health and treatment management. In addition to the names of prescription medications—both generic and brand named—I have introduced vitamins, homeopathic and herbal treatment interventions. Note: I am not recommending or suggesting that one medication is better than another. More importantly, you should never take any medication without a doctor’s prescription or guidance.

**Psychiatric Disorders - Alphabetical Listing**

The Alphabetical Listing is one of two sections in *A Diagnostic Psychiatric Primer* that supplies you with a complete list of the diagnostic disorders presented in the body of the book. The list does not include the additional disorders offered in the Additional Listings section. Similar to the body of the book I have elected to maintain the Psychiatric Association’s adopted list of psychiatric disorders.

Each entry is listed alphabetically with the ICD code in the first position. Notice the numbers are not in numerical order. The Numerical listing is offered in, Disorders–Numerical Code. Each entry is followed by the alphabetical listing of diagnoses and the accompanying subgroup category when applicable. I have included the specific page number of the diagnosis after each individual entry. You may want to refer to this list as a quick reference guide to an individual disorder.

**Psychiatric Disorders - Numerical Listing by Code**

The Numerical Listing by code is one of two sections in *A Psychiatric Diagnosis Primer*
that supplies you with a complete list of the diagnostic disorders presented in the body of the book. The list does not include the additional disorders offered in the Additional Listings section. Similar to the body of the book I have elected to maintain the Psychiatric Association’s adopted list of psychiatric disorders.

Each entry is listed numerically with the ICD code in the first position from the lowest code number to the highest code number. This entry is followed by the diagnosis associated with the code and the accompanying subgroup category when applicable. I have included the specific page number of the diagnosis after each individual entry. You may want to refer to this list as a quick reference guide to an individual disorder.

**Bibliography**

The identified bibliographic references include all the resources used to research and write *A Psychiatric Diagnosis Primer*. In most cases the references were used as a tool to support the compilation of the book. In some case such as the Additional Disorders section of the book, information was taken directly from the medical and psychology section of the Oxford Online Dictionary. I would like to specifically acknowledge the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders, IV-TR* (TM) and James Morrison’s *DSM-IV Made Easy*. The support information and data derived from these two works was invaluable.

**Index**

The index for *A Psychiatric Diagnosis Primer* contains every word that you may need to identify within the context of the book. As is the case with most indexes, use this section of the book to move quickly to the section or page that you would like to identify.
The Story of SamanthaLynn

by

Gary Solomon
Case Study

After some twenty years of working in the mental health field, specifically in the field of psychiatric diagnosis, I have continuously been frustrated with the structure of case study books relating to psychiatric diagnosis. I can recall my original training while working on my master’s and doctorate degrees. Attempting to comprehend the diagnostic and statistical manual of psychiatry disorders was an overwhelming task. In an attempt to supplement my learning and knowledge, I turned to case study books. Although written with good intent they are often full of material that side tracks the reader leading them ultimately to greater confusion. Today as an academic and researcher I work to resolve the ambiguity that exists in diagnostic analysis and case study presentation.

When the first edition of this book was released, the book did not contain a case study. The truth is, I had yet to solve the problem of how to present a case study that clearly paralleled the text on psychiatric diagnosis such that you, the reader, could see clear examples of how the case is directly linked to a particular psychiatric diagnosis. It was in late 2007 that I recognized the solution. Below you will find an individual story titled “Samanthalynn”. Instead of using numerous, separate stories, to identify a particular psychiatric illness; I am using Samanthalynn to describe every psychiatric disorder that is represented in this book. As you read the story I will give Samanthalynn certain and specific characteristics that are pathogenominic to the illness that Samanthalynn will be described as having. As soon as I do I will supply you with the diagnosis. Additionally you will be supplied with the page number that will link to that diagnosis that will supply you with more information about the diagnosis. This process should supply you with an easy to read, simple to use, learning tool to comprehend psychiatric illness.

Before entering into the story of Samanthalynn I would like to caution you of a few important points. First, this story and accompanying diagnoses, will not take into account the differential diagnosis. At the time of the writing of this text I am looking at a way that I might include a story that encompasses every possible different diagnosis. I would simply say at this time that to do such a writing as part of this text could make the book an excess of a thousand pages. Second, the new student to the field of psychology and psychiatry should not consider that an individual could suffer from every psychiatric illness; rather the story is a paradigm to present those illnesses as a learning mechanism. I would also invite you to recognize, as stated earlier in
the text, all human beings experience some degree of each psychiatric presentation, though those presentations may not affect the individual lives. Finally, keep in mind that this book is structured alphabetically therefore disorders are listed on each page in their alphabetical relation to the disorder before and after. Once you have investigated an individual page to look at single psychiatric diagnoses I would strongly recommend that you turn to the psychiatric group under which that psychiatric disorder falls. For instance, I may discuss Bi Polar 2 Disorder. Once you have looked up Bi Polar 2 Disorder take the time to look at the category of mood disorders. If you practice this you will find that you will quickly memorize the categories for each of the individual disorders. Good luck on the journey.

Gary Solomon, MPH, M.S.W., Ph.D., Professor of Psychology
The Story of SamanthaLynn

“Don’t play in the tunnel!” She told them over and over again. “Ya’ hear me? Don’t play in that tunnel. It’s too dangerous. You’re gonna get yourselves killed.” She could not have been clearer; she could not have been more firm or adamant. Yet each time she screamed the plea, her twin boys Timmy and Robert Jr. yelled back, ‘Why? You’re just scared of nothin’. There’s no train on that track anymore. And anyway, if we hear a train we can always run out the other end. You’re just being stupid, Mom. You’re being a fradycat.”

It was the same story every time: She’d plea with them; they’d argue with her. She would make them promise to stay away from the tunnel, and they would play in the tunnel anyway. SamanthaLynn tried telling herself that it didn’t matter; that they wouldn’t get hurt, but she never believed her own unconvincing mantra. It was no surprise to her when she heard a loud knock from her front door from the police one Tuesday afternoon informing her of the accident.

“I’m sorry, SamanthaLynn,” bemoaned the police chief. “These kids didn’t have a chance. I mean, there’s not more than an inch to spare on either side of that tunnel. There was no place for them to go.” Handing her a torn paper bag, slightly stained with the blood of her two young boys, he said, “This is all we’ve been able to find. It’s all that’s left. I’m terribly sorry, SamanthaLynn. I am so, so sorry.”

As Officer Gilbert drove off, SamanthaLynn remained frozen at the opening of the door to her small two-bedroom home. She had inherited the home from her parents who died almost ten years earlier. Just one day after the birth of her twin boys.

By the next day SamanthaLynn had tossed whatever belongs she thought she needed into the blue 1998 Chevy truck that her ex husband, Robert, bought her three years earlier. The gift came just a few months before he decided to leave, never telling where he was going; never returning to their home. Pulling the truck to the end of the driveway, she stopped to look at the unruly flames bursting from the windows of the place she had called home for all thirty-one years of her life. **Breaking the silence of the moment, she heard the spilling sound of a fire truck coming toward her from the opposite end of the small community she would never see, or want to see, again.** Never again would she mention the tragedy, the ungodly event that changed the course of her life.

From that point on she drove, passing the deafening wails of the fire engines that seemed to be screaming the cries of anguish and pain she felt. “Drive, Sam. Just drive,” were the only
words of encouragement she could mumble to herself as she sped away from the only life she
knew.

Maybe California? where she could walk along the sand and watch the tide wash away
her footsteps as quickly as she imprinted them. Or maybe the East coast. New York possibly?
The busy city might keep her so occupied that she wouldn’t have the time to think or grieve for
all that was lost. She could just pass through life in the bustle of the city, like the other
emotionless human shells.

She began to think of her boys, how much they had filled up her life every day with joy,
in every way a person possibly could. She thought of how empty she felt now that all she had
ever loved was nothing more than a memory to her, a chapter in time that had ended all too
quickly.

Suddenly she jolted from her thoughts and back into reality by the sputter of her engine.
She looked down at the gauges and wondered how long her gas light had been on. She pulled
into a gas station that was conveniently on her left hand side. Robotically she asked the attendant
for $40 on pump 3. She didn’t even have to think of what she was doing as she filled her tank
mechanically; doing the same things she had done for the past ten or so years. Following the
same routine, the same gas station, the same truck... the only thing that wasn’t the same was her
life and everything in it.

Once again she was struck back into reality by the feeling of liquid hitting her bare,
sandaled feet. She shook her feet dry and got behind the wheel of her truck. She barely noticed
her neighbor of 23 years waving at her from behind his silver Honda at the next pump. She
couldn’t even gather the courtesy to wave back in reply. Somehow it didn’t matter anymore to
her to follow the rules of common courtesy that most lived by in her small town. She had lost the
desire to care.

She didn’t care that she had $4.87 left on pump 3. She didn’t care that she had no idea
which direction she was going. As she pulled back onto the road, her foot still damp from the
gasoline, she didn’t notice the faint smell of gasoline enveloping her small truck cab, or that the
end of her skirt was stuck beneath the door frame and flapping furiously in the wind. She most
definitely didn’t notice the car that had been parked at the gas station, observing her every
robotic move, which was now following her at an unalarming distance. All she took notice of
was the song playing on her static filled radio. It had been her sons’ favorite song. For the first
time in many years she reflected on her unhappy and unrewarding past growing up on Bricker Lane.

Bricker Lane is as unpleasant a place to be born as one might envision. The seemingly endless dirt path that acted as Bricker Lane’s slightly navigable road eventually connected to a rutted, poorly paved cross street on the outer most region of Bernalillo, a small and unmemorable town 55 miles outside of Albuquerque, New Mexico. The almost forgotten, pocked dirt road dead ended in front of an old rundown shack that Randal and Kathryn Mason somehow managed to call home. Whoever named the street did so with a great deal of optimism.

The five room house which included a failing kitchen and a poor excuse for a bathroom was held up by weakening stilts that skirted the rim of the house. The white paint, now almost completely unrecognizable from the years of neglect, was the only redeeming quality to the metal roofed shanty. The two wooden steps that lead to the porch were long since gone, replaced by three rotten planks that stretched from the ground to the ailing wood porch. If ever a house did not look like a home it was the shabby residence located at 117 Bricker Lane.

Although she had no way of knowing the unfortunate day to which she was being born, Samantha Lynn would soon learn her fate. For it was on December 7, 1975 that she would first see the light of day. And it was on that day some 33 years earlier that Japan’s air force bombed Pearl Harbor, killing Randal Mason’s father in the process. As soon as his mother received word from the man in a roving topless gray jeep who spent his days informing wives that they were now widows, Randal’s mother walked into a hall closet that bedded her husband’s shot gun, put the oiled barrel well into her dry mouth and with her toes wrapped on the trigger blew her head completely off her body.

It would be from that day forward that Randal Mason learned to loathe December 7 and any event even remotely connected to that date. Shuttled from one foster home to another, Randal was inured to abuse that would become the cornerstone of his personality. At the age of eleven, Randal’s grandfather took over raising his grandson. Having gone deaf as a result of operating jack hammers in the perdition of the Pennsylvania coal minds, Randal’s grandfather was banished by the physicians to live in the middle of the hot, dry climate of New Mexico to help keep him alive one day at time. With Randal as his primary caretaker, his grandfather taught the young boy everything he needed to know about how to down a bottle or two of got-rot whisky. It was on that whisky that Randal grew to be a tall, handsomeless young man.
Having quit high school at the age of fifteen, the school board was overjoyed to be rid of the boy who offered trouble to anyone who crossed his path. Finding a job changing tires and oil on cars that had long since lost their heart, Randal lived day to day in the house that his grandfather left him when Randal was twenty-six. Though it appeared unlikely that anyone would ever want this recalcitrant and hard bitten young man, he found and married a young homeless girl named Kathryn. She had learned to put up with his maltreatment of her for the right to live under a roof.

While Randal was away at work or drinking the night into the next day, Kathryn slowly turned their shack of a house into a real home. Little by little she fixed what she could. If she needed Randal for some money or muscle to repair the house, she would use her body on him at the same time requesting these favors. Since Randal was always drunk, he never figured out that Kathryn was simply selling her body and her soul to have a home, something she had learned to do as a child.

While Kathryn squatted in the chipped tiger paw tub in their only bathroom moaning to give birth to the reluctant SamanthaLynn, Randal drank himself into a promise: he would teach this new kid of his what being born on the same day that his parents left him was all about. Turning up the music on the radio, the bacchanalian Randal Mason was sent as far away from his young wife’s scream as he would need to get through the next fourteen hours of SamanthaLynn’s birth.
Adjustment Disorders

Adjustment Disorders consist of individuals with mental disorders who are having a difficult time adjusting to life situations. The adjustment problems exist to a degree that they develop clinically significant behavioral and emotional symptoms as a direct result of a psychosocial stressor. These difficulties are beyond what would be expected for a given situation. The adjustments may be related to new jobs, being fired, death, ending of a romantic relationship, business problems, natural disaster, inability to attain personal goals, ending of a friendship, relocation, etc.

Possibilities

As a result of SamanthaLynn losing her children in the train accident, she suffers from problems relating to adjusting to her new life without her children.

Adjustment Disorder

She moves to New York and attempts to hide herself in the fast-paced lifestyle. For a number of reasons, including the geographical shift, she suffers from:

Culture Shock

Disorders in this Category

Adjustment Disorder
Culture Shock
Anxiety Disorders

Individuals with Anxiety Disorders experience abnormal or inappropriate levels of heightened anxiety. These individuals do not react to particular stimuli with the normal Fight or Flight response: that is, by either fighting or abandoning the environment or situation. Instead, these individuals become overly anxious as a result of the presence or anticipation of the presence of a particular stimulus; their reaction to the stimulus is unwarranted.

As a result of SamanthaLynn's difficult life experiences, she suffers from multiple anxiety disorders. She has never been clinically diagnosed.

Possibilities

She lives a life of sadness, restlessness, exhaustion, and fear of the future.
**Generalized Anxiety Disorder**

She spent her childhood sad, restless, exhausted, and fearful of the future.
**Overanxious Disorder**

She is shocked and traumatized as a result of the events regarding the death of her two children.
**Acute Stress Disorder**

She is shocked and traumatized as a result of the events regarding the death of her two children for more than thirty days.
**Post Traumatic Stress Disorder, Survivor Syndrome**

She shifts her fear of small places onto her children and experiences feelings or sensations of panic as her children play in the tunnel.
**Agoraphobia With History of Panic Disorder**

She shifts her fear of small places onto her children but does not experience feelings or sensations of panic as her children play in the tunnel.
**Agoraphobia Without History of Panic Disorder**

> Her emotional reaction could be flip flopped. She may feel panic first, along with the Agoraphobia, making the diagnosis **Panic Disorder With Agoraphobia**. If it is only a sense of panic, the diagnosis would be **Panic Disorder Without Agoraphobia**.

She experienced depression in her early childhood.
**Anaclitic Depression**

She experienced depression in her early childhood as a result of frequent trips to the hospital due to multiple and continuing medical illnesses.
**Hospitalism**
She developed a Streptococcal infection while checked in to a hospital and as a result developed an anxiety disorder.

_Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections_

She had various childhood onsets relating to obsessions and compulsions.

_Obsessive-Compulsive Disorder,  Obsessional Neurosis, Transference Neurosis_

She has a specific phobia, for example: a phobia of trains and tunnels.

_Anxiety Hysteria, Specific Phobia, Simple Phobia_

She has a phobia of locations including other people whom she may have to encounter.

_Social Phobia_

She dreads developing cancer.

_Anxiety Disorder Due to a General Medical Condition_

She is anxious yet unable to describe her symptoms clearly.

_Anxiety Disorder Not Otherwise Specified_

She quickly abandons her home as it burns to the ground, leaving no time to stabilize herself emotionally.

_Hysteria_

She experiences certain emotions as a result of actions against her by an unwitting victimizer.

_Marshall Long-Term Syndrome_

She remembers the suicide of Margo Thomas, a famous singer whom she loved and worshiped, resulting in her own consideration of suicide.

_Werther Syndrome_

You may recall that Randall, SamanthaLynn's father, was quite a terror to the rest of the school kids. It is suspected that he suffers one of the following possible anxiety disorders.

He has memories that affect him negatively as a result of the things he did to the other children, though the other children do not.

_Chandler Long-Term Syndrome_

He suffers from an anxiety disorder coupled with multiple substances provided by his grandfather, Otis.

_Substance-Induced Anxiety Disorder_

SamanthaLynn's mother, Kathryn, is suspected to have a few anxiety disorders of her own. The possibilities are as follows:

She collects and saves everything and cannot throw anything away.

_Compulsive Hoarding_
She collects and saves everything, cannot throw anything away, and presents other aberrant behaviors.
Defense Hysteria, Retention Hysteria

She is shocked by the home birth of her only child, SamanthaLynn, and is sent into a hypnotic state.
Hypnoid Hysteria

She is easily startled and reacts to sudden sounds or movements but does not experience defense hysteria.
Exaggerated Startle Reaction, Familial Startle Disease, Hyperexplexia, Hyperekplexia, Kok Disease, Raggin' Cajun

She has fears of harming other people including her child, SamanthaLynn.
Harming Disorder

One of SamanthaLynn's sons, Timmy, was not known to suffer any anxiety disorders. Robert Jr., however, was thought to have suffered the following:

He feels deprived and detached from others due to the lack of participation of his father in his upbringing.
Maternal Deprivation

He feels deprived and detached from others due to the lack of participation of his father in his upbringing, resulting in more extensive and related problems as he travels further into his adolescent and teenage years.
Separation Anxiety Disorder
Disorders in this Category

Acute Stress Disorder
Agoraphobia With History of Panic Disorder
Agoraphobia Without History of Panic Disorder
Anaclitic Depression
Anxiety Disorder Due to a General Medical Condition
Anxiety Disorder Not Otherwise Specified
Anxiety Hysteria
Chandler Long-Term Syndrome
Compulsive Hoarding
Defense Hysteria
Exaggerated Startle Reaction
Familial Startle Disease
Generalized Anxiety Disorder
Harming Disorder
Hoarding Disorder
Hospitalism
Hyperekplexia
Hyperexplexia
Hyperstartle Disorder
Hypnoid Hysteria
Hysteria
Infections
Kok Disease
Marshall Long-Term Syndrome
Maternal Deprivation
Obsessional Neurosis
Obsessive-Compulsive Disorder
Overanxious Disorder
Panic Disorder with Agoraphobia
Panic Disorder without Agoraphobia
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Post Traumatic Stress Disorder
Raggin’ Cajun
Retention Hysteria
Separation Anxiety Disorder
Simple Phobia
Social Phobia
Specific Phobia
Startle Disorder
Substance-Induced Anxiety Disorder
Survivor Syndrome
Transference Neurosis
Werther Syndrome
Culture-Bound (Disorders) Syndromes

Culture-Bound (Disorders) Syndromes are patterns of aberrant behavior that do not fit easily into standard classifications of mental disorders. They are entirely or mainly restricted to particular cultural groups, usually and ethnocentrically excluding disorders such as Anorexia Nervosa that are restricted to Western industrial cultures. Social class and gender may further impact patterns of behavior both within and outside a given culture.

Do you remember the mystery man who follows SamanthaLynn at the beginning of the story? All we know of him is that he is from a foreign country and suffers from one or more disorders or syndromes found only in the noted locations below.

Possibilities

He is from Malaysia, Indonesia, Laos, the Philippines, Papua New Guinea, Polynesia, Puerto Rico, or among the Navajo in North America, and was bruting as a result of an insult that caused him to become aggressive. He now goes through periods of ideation, exhaustion, and ultimately amnesia regarding his violent behavior.

Amok, Mal De Pelea, Iich’aa, Cafard

In the United States, behavior such as walking into a building and randomly shooting people or taking shots from a tower is known as **Running Amok**.

He is from the Caribbean or other Latin American and Mediterranean cultures and uncontrollably shouts, cries, trembles, and is aggressive both verbally and physically with a loss of self control.

Ataque De Nervios

He is from one of the Latin American communities and experiences intense anger or rage, nervous tension, headaches, trembling, screaming, upset stomach, and chronic fatigue.

Bilis, or Colera

He is from Francophone, West Africa or Haiti, and is known to have sudden outbursts of violent behavior, periods of confusion, psychomotor agitation, and possible paranoid ideations and hallucinations.

Bouffée Délirante

He is from West Africa and was first taught and then required to speak English in school, but lost his ability to concentrate, learn, remember, or think, and experienced sensations of pain, pressure, or tightness around the head or neck.

Brain Fag
He is from India and suffers from severe anxiety along with hypochondria. His focal problems are weakness and exhaustion specifically attributed to excessive secretion of semen. **Dhat**

Also written as Dhatu. Also known as Jiryan, Shen-k'uei, or Sukra Premeha in Sri Lanka.

He is from Southern United States or the Caribbean and exhibits behavior of sudden collapse, brief dizzy spells, and/or sensations of blindness with an inability to speak or move. **Falling Out**

He is among the Miskito Indians of Nicaragua and suffers from headaches, anxiety, anger, and/or aimless running. **Grisi Siknis**

He is among the Mohave American Indians and relays symptoms of insomnia, depression, loss of appetite, and/or suicidal ideation. **Hi-Waitck**

He is Taiwanese and experiences brief trances including tremors, disorientation, and delirium. **Hsieh-Ping**

He is from Korea or immigrant Korean communities in other countries and suppresses anger; experiences panic attacks, dyspnoea, thanatophobia, insomnia, and/or joint muscle pain. **Hwa-Byung**

He is an ethnic member of a Chinese community in Southern or Eastern Asia and has anxiety that his penis is shrinking. **Koro**

He is from Malaysian, Indonesian cultures or Southern Africa and is overly or abnormally suggestible and experiences Echolalia, Echopraxia, or trance-like states. **Latah**

Also written as Lattah. Also known as Bah Tschi in or Baah-ji in Thailand, Malimali or Silok in the Philippines, Imu amongst the Ainu people of Japan, and Amurakh, Irkunii, Ikota, Olan, Myriachit, or Menkeiti in Siberia.

He is from Latin America or among Latino communities in the United States. He is incoherent and experiences auditory and visual hallucinations with occasional outbursts of violence or aggression. **Locura**

He is from parts of Latin America or Latino communities in the United States and experiences chronic anxiety and psychosocial stress brought about through family difficulties, headaches, tearfulness, tremor, and/or dizziness.
**Nervios**

- Also known as Nerfiza in Egypt and Nevra in Greece.

He is from China or Southeast Asia and is afraid of the cold - Frigophobia - or the wind - Anemophobia - and causes him to be fatigued, impotent, and afraid of death.

**Pa-Leng**

He is from a community in North America or Greenland and experiences fatigue, social withdrawal, and irritability that leads to taking off his clothes and practicing antisocial behavior such as Seudolalia, Echolalia, and Echopraxia.

**Pibloktoq**

He is from a Chinese community in southern or eastern Asia and exhibits paranoid ideation, dissociation, and psychotic signs and symptoms.

**Qi-Gong Psychotic Reaction**

He is from the Caribbean, African American, or Latino communities in the southern United States, where witchcraft, sorcery, and hexing is being practiced. He complains of anxiety, gastrointestinal complaints, weakness, dizziness, and the fear of being poisoned or killed.

**Rootwork**

He is from the Portuguese speaking Cape Verde Islands or is an immigrant from Cape Verde communities and suffers from muscle and joint pain, numbness, trembling, paralysis, and blindness.

**Sangue Dormido**

He is a member of a Chinese community in southern or eastern Asia and suffers from fatigue, dizziness, headaches, joint and muscle pain, gastrointestinal complaints, sexual dysfunctions, dyssomnias, and amnesia.

**Shenjing Shuairuo**

He is from Thai Land or ethnic Chinese communities in southern and eastern Asia and suffers from anxiety, panic attacks, somatic complaints, insomnia, sexual dysfunctions, dizziness, and back aches. His symptoms are attributed to a loss of semen brought about as a result of excessive sexual intercourse, masturbation, nocturnal emissions, and the passing of whitish urine.

**Shen-K’uei**

He is from Korea or Korean communities and experiences anxiety, dissociation, insomnia, dizziness, fatigue, gastrointestinal problems, and general asthenia.

**Shin-Byung**

He is from sub-Saharan Africa or among African-American or Latino communities in the southern United States. He experiences personality changes where he believes dead relatives are speaking to him as a result of being appointed to a position of privilege by dead ancestors.
He is either from Peru or other parts of Latin America or originates from Spanish speaking communities in the United States. He has had a frightening experience where he believed his soul departed from his body, which is now causing him to have psycho motor agitation, insomnia, hypsomnia, nightmares, depressed mood, headaches, diarrhea, and muscle and joint pain. **Susto, Espanto, Perdida Del Alma, Tripa Ida**

He is from Trinidad and his wife abandons him. As a result, he experiences depression and attempts suicide. **Tabanka**

He is from Japan and experiences intense anxiety that one or more of his own body parts or body functions are embarrassing, displeasing, repugnant and/or offensive to others. **Taijin Kyofusho**

He is part of the Zulu speaking Xhosa speaking communities of Southern Africa and Kenya. He believes he is possessed by a spirit as a result of witchcraft and/or magical potions administered by rejected lovers or enemies and is characterized by shouting, sobbing, Seudolalia, paralysis, convulsions, sexual nightmares, and/or loss of consciousness. [Found mainly amongst women.] **Ufufunyane**  
**Saka**

He is from the Inuit communities of northern America and Greenland and suffers from sensations from a particular sound or smell followed by a sudden paralysis, anxiety, psychomotor agitation, and/or hallucinations, all attributed to the loss of his soul or spirit possession. **Uqamairineq**

He is amongst a North American Indian tribe and suffers from a rare disorder characterized by depression, homicidal or suicidal thoughts, and the compulsive desire to eat human flesh. **Windigo**

〉 Also written as **Wendigo and Whitigo.**

He is from Ethiopia, northern Africa, or Arab communities in various parts of the Middle East and believes he is possessed by a spirit. He exhibits shouting, laughing, self injury, self mutilation, singing, and/or weeping, followed by apathy and withdrawal. **Zar**
Disorders in this Category

Amok
Ataque De Nervios
Bilis
Bouffée Déliante
Brain Fag
Cafard
Colera
Dhat
Espanto
Fag Brujeria
Falling Out
Ghost Sickness
Grisi Siknis
Hi-Waitck
Hsieh-P'ing
Hwa-Byung
Iich'aa
Koro
Latah
Locura
Mal De Ojo
Mal De Pelea
Mal Puesto
Nervios
Pa-Leng
Perdida Del Alma
Pibloktq
Qi-Gong Psychotic Reaction
Rootwork
Saka
Sangue Dormido
Shenjing Shuairuo
Shen-K'uei
Shin-Byung
Shinkei-Shitsu
Spell
Susto
Tabanka
Taijin Kyofusho
Tripa Ida
Ufufunyane
Uqamairineq
Windigo
Zar
Delirium, Dementia, Amnestic and Other Cognitive Disorders

Individuals with Delirium, Dementia, Amnestic and Other Cognitive Disorders have problems with cognition; processing information. This chronic or persistent disorder is due to disease or injury. Memory problems, thinking problems, personality changes, and impaired reasoning characterize this problem. The memory and thinking problems relate to storage, retrieval, and manipulation of information.

Possibilities

You might recall that Otis, Robert's father, is somewhat ill. Having to retire in the dry, New Mexico desert, Otis suffers from a wide range of problems. Some of his problems relate to Delirium. He has yet to receive an in-depth examination, so his problems with Delirium are not clearly diagnosed.

Delirium Not Otherwise Specified

He experiences reduced levels of consciousness, difficulty focusing, and/or shifting or sustaining attention, occurring over a matter of hours to days [which are typically characteristic of Delirium].

Delirium Due to a General Medical Condition, Delirium Due to Multiple Etiologies, Substance-Induced Delirium

His conditions are similar to but are far more pervasive than delirium, last more extensively over time, and present multiple complications. His conditions are likely connected to the disease of the central nervous system.

Agnosia, Aphasia, Apraxia, Dementia Due to Creutzfeldt-Jakob Disease

He is unable to learn new information or previously learned information.

Dementia Due to Head Trauma, Dementia Due to HIV Disease, Dementia Due to Huntington's Disease, Dementia Due to Parkinson's Disease, Dementia Due to Pick's Disease, Dementia of the Alzheimer's Type, Dementia Due to Multiple Etiologies, Dementia Not Otherwise Specified, Pick's Disease, Lewy Body Dementia, Substance-Induced Persisting Dementia, Vascular Dementia

Each of the dementia in these cases have separate characteristics, such as the origin in the frontal lobe, personality changes, perceived intellectual capability, temporal lobe impairment, and/or early onset of continuous deteriorating psychosis.

Other problems of Otis' relate to amnesia.

He experiences amnesia related to a loss of neurons in the diencephalons, especially in the midline thalamus.

Diencephalic Amnesia

He exhibits a fabrication of events, experiences and/or facts without conscious intent.

Confabulation
He believes that he has a double or replica. 
**Doppelgänger**

He is unable to retain newly acquired information but with undisturbed previously acquired information.  
**Korsakoff's Psychosis, Korsakoff's Syndrome, Alcohol Amnestic Syndrome, Alcohol Amnestic Disorder**

He is incapable of remembering anything prior to the age of three.  
**Infantile Amnesia, Childhood Amnesia**

Otis' problem relates to a psychogenesis rather than part of an organic disorder. He leaves home and creates a new life somewhere.  
**Psychogenic Fugue**

He remembers information but is unable to recall where or from whom of how the information is obtained.  
**Source Amnesia**

He suffers from a sudden loss of memory [both anterograde and retrograde amnesia] but recovers within 24 hours.  
**Transient Global Amnesia**

He sees a familiar object but believes that it actually resembles another “real” object.  
**Reduplicative Paramnesia**

He experiences amnesia as a result of being exposed to organophosphates.  
**Organophosphate Poisoning**

He suffers from an amnestic disorder as a result of an intentional intake of substances such as alcohol and drugs.  
**Substance-Induced Persisting Amnestic Disorder**

He experiences amnesia as the result of general medical problems.  
**Amnestic Due to a General Medical Condition**

He experiences amnesia but his clinician is suspicious where his diagnosis lies.  
**Amnestic Disorder Not Otherwise Specified**

If the diagnostician has other possibilities to consider, the clinical may want to take into account some or all of the following.

He believes something as the result of information that he has received which in fact is incorrect.  
**Misinformation Effect**
He observes something but does not correctly relate the information.  
**Eyewitness Misinformation Effect**

He is told something that is untrue and acts upon that misinformation.  
**Cruise Effect**

He had events occur in his childhood that he simply no longer remembers.  
**False Memory, False Memory Syndrome**

He has false memories of his childhood as a result of being kidnapped.  
**Piaget Kidnapping Memory**

His memory is affected by a traumatic event [the opposite of false memory syndrome].  
**Recovered Memory**

He was a kidnap victim and sided with his kidnappers.  
**Stockholm Syndrome**

He suffers from different variations of believing that he is heard, seen, felt, believed, or has been somewhere before.  
**Déjà vu**

He confuses facts versus fantasy.  
**Paramnesia**
Disorders in this Category

**Delirium**
- Delirium Due to a General Medical Condition
- Delirium Due to Multiple Etiologies
- Delirium Not Otherwise Specified
- Substance-Induced Delirium

**Dementia**
- Dementia Due to a General Medical Condition
- Dementia Due to Creutzfeldt-Jakob Disease
- Dementia Due to Head Trauma
- Dementia Due to HIV Disease
- Dementia Due to Huntington’s Disease
- Dementia Due to Multiple Etiologies
- Dementia Due to Parkinson’s Disease
- Dementia Due to Pick’s Disease
- Dementia Not Otherwise Specified
- Dementia of the Alzheimer’s Type
- Dementia Praecox
- Lewy Body Dementia
- Multi-Infarct Dementia
- Pick's Disease
- Substance-Induced Persisting Dementia
- Vascular Dementia

**Amnestic**
- Alcohol Amnestic Disorder
- Alcohol Amnestic Syndrome
- Amnestic Disorder Not Otherwise Specified
- Amnestic Due to a General Medical Condition
- Childhood Amnesia
- Confabulation
- Diencephalic Amnesia
- Doppelgänger
- Global Amnesia
- Infantile Amnesia
- Korsakoff's Psychosis
- Korsakoff's Syndrome
- Organophosphate Poisoning
- Psychogenic Amnesia
- Psychogenic Fugue
- Reduplicative Paramnesia
- Source Amnesia
Substance-Induced Persisting Amnestic Disorder
Transient Global Amnesia (Pg. 334)

*Other Cognitive Disorders*

Cognitive Disorder Not Otherwise Specified
Cruise Effect
Déjà vu
Eyewitness Misinformation Effect
False Memory
False Memory Syndrome
Misinformation Effect
Paramnesia
Piaget Kidnapping Memory
Recovered Memory
Stockholm Syndrome
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

General Characteristics

Individuals with Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence have mental disorders that begin in early childhood. It should be noted that other psychiatric disorders may occur in childhood. Additionally, some of the childhood disorders may persist into adulthood.

Let’s take some time and focus our energy on SamanthaLynn's two young children Timmy and Robert Jr.

Possibilities

Timmy is unable to sit still, has difficulty concentrating on any task, and cannot follow through with any projects that he is assigned.

Attention-Deficit/Hyperactivity Disorder

He is simply unable to focus his attention or concentrate.

Attention-Deficit Disorder

He may not fill enough of the criteria for this category.

Hyperkinetic Disorder

Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

He may not fill enough of the criteria for this category, and he is less than five years old.

Hyperkinesis Disorder

Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified

His teachers complain that he intentionally disrupts the classroom and refuses to take direction.

Conduct Disorder

Oppositional Defiant Disorder

His disruptive behavior is not clearly defined.

Disruptive Behavior Disorder Not Otherwise Specified

As a result of numerous viral problems, Timmy suffers from Attention Deficit/Hyperactivity Disorder.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

Timmy is unable to comprehend language which is significantly below that of his expressive ability and/or non verbal intelligence.

Receptive Language Disorder

He has problems articulating sounds and/or producing unexpected sounds while speaking.

Phonological Disorder

He is not able to comprehend the information that he is receiving. He has a limited vocabulary
and experiences poor recall of words.

**Expressive Language Disorder**

Timmy suffers from two of the previous four mentioned groups.

**Mixed Receptive-Expressive Language Disorder**

Robert Jr. is unable to articulate in complete and full sentences without stuttering or stammering.

**Phonological Disorder**

He meets some of the criteria for the above but not enough for a complete diagnosis.

**Communication Disorder Not Otherwise Specified**

Timmy and Robert Jr. are older than four years old and suffer from bed wetting.

**Enuresis**

Robert Jr. passes fecal matter throughout the day into his clothing, shower, bed, etc.

**Encopresis**

He throws up his food in his mouth and swallows it again.

**Rumination**

He eats non nutritional items such as paper clips, hair pins, and even paper.

**Pica**

On several occasions he eats fecal matter.

**Coprophagia**

Timmy frequently eats

*(Dirt) Geophagia, (glass) Hyalophagia, (ice) Pagophagia, (hair) Trichotillophagia*

He deals with numerous problems associated with feeding and eating, none of which fall clearly into a category.

**Feeding Disorder of Infancy or Early Childhood**

Robert Jr. has several neurological problems associated with his inability to perceive objects correctly or tell time.

**Agnosia**

He is unable to tell one object from another when he touches that object.

**Tactile Aphasia**

He is plagued with problems associated with written numbers, translating spoken word, and establishing a spelling vocabulary, etc.

**Agraphia**

**Disorder of Written Expression**
He is plagued with problems associated with written numbers, translating spoken word, and establishing a spelling vocabulary, etc., as the result of a neurological disorder.

**Dysgraphia**

His has abnormal motor functioning, spontaneous speech, and recollection of words.

**Aphasia**
**Broca's Aphasia**
**Conduction Aphasia**

Timmy has problems with reading, writing, and arithmetic.

**Academic Skills Disorder**
**Specific Disorder of Arithmetic Skills**
**Specific Spelling Disorder**
**Spelling Dyslexia**

The focus of his problems is associated with arithmetic.

**Mathematics Disorder**
**Acalculia**
**Dyscalculia**

The focus of Robert Jr.’s problems is associated with reading.

**Reading Disorder**

He has complications associated with advanced word recognition.

**Hyperlexia**

Robert Jr. has problems with reading due to head trauma.

**Acquired Dyslexia**

He has difficulty identifying the physical properties of certain shapes and sizes.

**Ahylognosis**
**Spelt Ahylognosis**

Timmy was born with problems associated to written or printed words.

**Dyslexia**
**Alexia**

The problem emanates from his central nervous system, evidenced by post verbal attempts. Additional complications may occur.

**Central Dyslexias**
**Deep Dyslexia**
**Surface Dyslexia**
**Developmental Dyslexia**

Timmy has problems with listening and spelling.

**Phonological Dyslexia**
His problems with listening and spelling are evaluated through Cognitive Neuropsychology.

He is unable to recognize objects by their size and shape.
Amorphognosis
Amorphognosia

He has issues associated with naming individual letters when two are presented simultaneously.
Attentional Dyslexia
Visual Word-Form Dyslexia
Peripheral Dyslexia
Word Blindness

Robert Jr. transposes and/or reverses letters.
Strephosymbolia

From his perspective, objects are perceived in a mirror image. He occasionally has difficulty recognizing his own body.
Autotopagnosia
Finger Agnosia
Topagnosia

He is unable to perceive one object or image at the same time.
Simultanagnosia

Timmy is mentally retarded due to the deletion of chromosome 17. His mental retardation hampers his ability to learn.
Smith-Magenis Syndrome

Robert Jr. suffers from problems associated with early childhood alcohol dependency.
Gait Ataxia
Gargoylism

He has visual problems as a result of damage to the bilateral portion of his brain.
Bálint's Syndrome

Upon occasion he flails his limbs to the point of exhaustion and incapacity to function.
Ballism

There are neurological problems characterized by left-right disorientation.
Gerstmann Syndrome

As a result of some damage to the corpus callosum, Timmy has problems responding to verbal requests with the left hand.
Left-Sided Apraxia
Callosal Apraxia
Sympathetic Apraxia
Unilateral Limb Apraxia

He repeatedly reads the same word or phrase.
Catalexia

He is having voice quality problems such as hoarseness or strain to the vocal chords.
Dysphonia

Timmy’s problems relate to his impairment of spontaneous speech to repeat the spoken word.
Transcortical Aphasia
Transcortical Motor Aphasia
Visual Aphasia
Transcortical Sensory Aphasia
Mixed Transcortical Aphasia
Wernicke's Aphasia

A lesion in the central nervous system affects Timmy's ability to coordinate voluntary movements.
Pseudoataxia

Robert Jr. has an impairment of sensation.
Sensory Ataxia
Dystaxia

It is not uncommon for Timmy to get lost, leaving him unable to find his way around or read maps due to a lesion in the right hemisphere parietal lobe.
Topographagnosia

Most or all of the mentioned conditions exist as a result of the interruption or blockage of the transferred information within the brain.
Disconnection Syndrome

One of Timmy’s female friends has three X chromosomes, resulting in deficits in auditory and language comprehension.
XXX Syndrome

A specific diagnosis for Robert Jr. is not possible.
Learning Disorder Not Otherwise Specified
Disorders in this Category

Attention Deficit and Disruptive Behavior Disorders

Attention-Deficit Disorder
Attention-Deficit/Hyperactivity Disorder
Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified
Ballism
Conduct Disorder
Disruptive Behavior Disorder Not Otherwise Specified
Hyperkinesis Disorder
Hyperkinetic Disorder
Oppositional Defiant Disorder
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

Communication Disorder

Communication Disorder Not Otherwise Specified
Developmental Articulation Disorder
Expressive Language Disorder
Mixed Receptive-Expressive Language Disorder
Phonological Disorder
Receptive Language Disorder

Elimination Disorders

Coprophagia
Encopresis
Enuresis

Feeding and Eating Disorders of Infancy or Early Childhood

Feeding Disorder of Infancy or Early Childhood
Geophagia
Hyalophagia
Pagophagia
Pica
Rumination
Trichotillophagia

Learning Disorders

Academic Skills Disorder
Acalculia
Acquired Dyslexia
Agnosia
Agraphia
Ahylagnosia
Alexia
Amorphagnosia
Amorphognosis
Aphasia
Attentional Dyslexia
Autotopagnosia
Bálint's Syndrome
Ballism
Broca's Aphasia
Callosal Apraxia
Catalexia
Central Dyslexias
Cognitive Neuropsychology
Conduction Aphasia
Deep Dyslexia
Developmental Dyslexia
Disconnection Syndrome
Disorder of Written Expression
Dyscalculia
Dysgraphia
Dyslexia
Dysphonia
Dystaxia
Finger Agnosia
Gait Ataxia
Gargoylism
Gerstmann Syndrome
Hyperlexia
Learning Disorder Not Otherwise Specified
Left-Sided Apraxia
Mathematics Disorder
Mixed Transcortical Aphasia
Peripheral Dyslexia
Phonological Dyslexia
Pseudoataxia
Reading Disorder
Sensory Ataxia
Simultanagnosia
Smith-Magenis Syndrome
Specific Disorder of Arithmetic Skills
Specific Spelling Disorder
Spelling Dyslexia
Spelt Ahylagnosia
Strephosymbolia
Surface Dyslexia
Sympathetic Apraxia
Tactile Aphasia
Topagnosia
Topographagnosia
Transcortical Aphasia
Transcortical Motor Aphasia
Transcortical Sensory Aphasia
Unilateral Limb Apraxia
Visual Aphasia
Visual Word-Form Dyslexia
Wernicke's Aphasia
Word Blindness
XXX Syndrome

*Mental Retardation*

Borderline Intellectual Functioning
Cerebral Gigantism
Cerebral Palsy
Cretinism
Cri Du Chat
Down's Syndrome
Fetal Alcohol Syndrome
Foetal Alcohol Syndrome
Fragile X Syndrome
Hurler's Syndrome
Klinefelter's Syndrome
Lesch-Nyhan Syndrome
Macrocephaly
Mental Retardation, Severity Unspecified
Microcephaly
Mild Mental Retardation
Moderate Mental Retardation
Monosomy X
Prader-Willi Syndrome
Profound Mental Retardation
Severe Mental Retardation
Shaken Baby Syndrome
Sotos Syndrome
Tay-Sachs Disease
Trisomy
Turner's Syndrome
Williams Syndrome
XXX Syndrome
XXY Syndrome
Motor Skills Disorder

Developmental Coordination Disorder

Other Disorders of Infancy, Childhood, or Adolescence

Adolescence Not Otherwise Specified
Anaclitic Depression
Disorder of Infancy, Childhood, or
Elective Mutism
Hospitalism
Overanxious Disorder
Reactive Attachment Disorder of Infancy or Early Childhood
Selective Mutism
Separation Anxiety Disorder
Stereotypic Movement Disorder

Pervasive Developmental Disorders

Asperger’s Disorder
Autistic Disorder
Childhood Disintegrative Disorder
Fragile-X Syndrome
Heller's Syndrome
Idiot Savant
Infantile Autism
Kanner's Syndrome
Mongolism
Pervasive Development Disorder Not Otherwise Specified
Rett’s Disorder
Williams Syndrome

Tic Disorders

Chronic Motor or Vocal Tic Disorder
Coprolalia
Copropraxia
Echolalia
Infections
Palilalia
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal
Tic Disorder Not Otherwise Specified
Tourette’s Disorder
Transient Tic Disorder
Dissociative Disorders

Individuals with Dissociative Disorders experience a disruption in consciousness, loss or lapse of memory and identity or perception that may be sudden or gradual, transient or chronic. In all cases, one of the aforementioned is not malfunctioning. The condition usually begins suddenly, may be caused by psychological conflict and, is relatively rare.

Possibilities

Robert's grandfather, Otis, has an array of problems relating to dissociation, though he could never bring himself to be checked thoroughly by a clinician to determine a clear pathology.

Dissociative Disorder Not Otherwise Specified

He had problems in his early twenties where he would often time wake up having lost track of time. For instance, sometimes Otis wouldn't be Otis any more he would be Oskar or Philip.

Dissociative Identity Disorder
Possession Trance

He wakes up and finds that he is in a different city, but does not know how he got there.

Dissociative Fugue
Dissociative Amnesia

He experiences spasmodic convulsions that look like epilepsy.

Dissociative Convulsions

He goes away in his mind in the middle of tasks such as driving his car or talking to someone, then forgets what he was doing.

Depersonalization Disorder
Trance
Dissociative Trance Disorder

He occasionally loses partial and/or complete ability to perform body movements.

Dissociative Movement Disorder
Dissociative Motor Disorders
Motor Dissociative Disorders

He experiences only fragmented, isolated parts of his memory, possibly as a result of his own childhood.

Polyfragmentation

He often answers that a bird has one wing when asked how many wings a bird has.

Ganser's Syndrome

He appears to have slight neurotic problems due to his odd combination of problems.

Depersonalization Neurosis
His complex problems are part of

Anxiety Hysteria

Disorders in this Category

Anxiety Hysteria
Depersonalization Disorder
Depersonalization Neurosis
Dissociative Amnesia
Dissociative Convulsions
Dissociative Disorder Not Otherwise Specified
Dissociative Fugue
Dissociative Identity Disorder
Dissociative Motor Disorders
Dissociative Movement Disorder
Dissociative Stupor
Dissociative Trance Disorder
Ganser’s Syndrome
Motor Dissociative Disorders
Polyfragmentation
Possession Trance
Trance
Eating Disorders

Those with Eating Disorders are individuals with mental disorders who have eating-related problems. These problems may relate to eating too much, eating in an unhealthy manner, or not eating enough.

Possibilities

SamanthaLynn is someone who takes good care of herself. She is not a junk food eater or someone who hits the drive through restaurants. However, over many years SamanthaLynn has noticeably suffered from a plethora of diagnostic eating disorders.

She is extremely thin an gaunt.  
**Anorexia Nervosa**

She is of average or normal weight. She purges her body consistently through self-induced vomiting, laxatives, diuretics, and/or enemas.  
**Bulimia Nervosa**

She is pro-Anorexia Nervosa.  
**Ana's**

She is pro-Bulimia Nervosa.  
**Mia's**

She is gaining weight rapidly as a result of compulsive-eating.  
**Binge-Eating Disorder**

She has a skewed self-image.  
**Dysmorphobia**

She finds it necessary to have a complete physical examination including an MRI. Her MRI indicates that there is a brain lesion that may be causing her eating disorder.  
**Hyperorexia**

She is suffering from Hyperorexia located in the hypothalamic area of the brain.  
**Lateral Hypothalamic Syndrome**

She is suffering from Hyperorexia located in the medial forebrain bundle.  
**Hyperphagia**

She is suffering from Hyperorexia located on both sides of the ventro medial hypothalamus.  
**Ventralmedial Hypothalamic Syndrome**  
**Hypothalamic Hyperphagia**

She over eats as a result of an indication of mental retardation.
Prader-Willi Syndrome

Disorders in this Category

Ana’s
Anorexia Nervosa
Binge-Eating Disorder
Bulimia Nervosa
Dysmorphobia
Eating Disorder Not Otherwise Specified
Hyperorexia
Hyperphagia
Hypothalamic Hyperphagia
Lateral Hypothalamic Syndrome
Mia’s
Prader-Willi Syndrome
Ventromedial Hypothalamic Syndrome
Factitious Disorders

Those with Factitious Disorders are individuals with mental disorders whose physical and psychological symptoms are deliberately produced or feigned for the sole purpose of receiving medical attention from health care professionals. An individual with a Factitious Disorder is different from those who malingering for the purposes of receiving monetary compensation, time off from work, relief from responsibility, etc.

Possibilities

Robert Sr. and his mother, Evelyn, privately suffered from factitious disorders for the majority of their adulthood. From time to time family members and doctors suspected its existence, but Robert Sr. and Evelyn cleverly avoided formal diagnosis.

Factitious Disorder Not Otherwise Specified

Evelyn often makes up illnesses at various medical offices.
Factitious Disorder, Hospital Hopper Syndrome, Pathomimicry

She intentionally makes Robert Sr. sick to the point of requiring immediate medical attention.
Münchausen by Proxy Syndrome, Factitious Disorder by Proxy, Peregrinating Patient

Robert Sr. lies about simple things like how many legs a dog has and what color the sky is.
Ganser's Syndrome, Nonsense Syndrome

Robert Sr. suffers from factitious disorders in a brief stay in an Arizona state detention facility.
Prison Psychosis

Robert Sr. invents rather incredible lies and stories at an escalated level.
Pseudologia Fantastica

Robert attempts suicide upon hearing news of his favorite singer's tragic suicide.
Werther Syndrome
Disorders in this Category

Factitious Disorder
Factitious Disorder by Proxy
Factitious Disorder Not Otherwise Specified
Ganser’s Syndrome
Hospital Hopper Syndrome
Hypothalamic Hyperphagia
Münchausen by Proxy Syndrome

Nonsense Syndrome
Pathomimicry
Peregrinating Patient
Prison Psychosis
Pseudologia Fantastica
Werther Syndrome
Impulse-Control Disorders

Those with Impulse-Control Disorders are individuals with mental disorders who fail to, or have extreme difficulty, controlling impulses. The impulses typically have negative consequences. The individual feels mounting tension. As the tension increases there is a strong, irresistible need to perform a harmful act against oneself or someone else. Upon completion of the act, the individual feels a sense of gratification, pleasure, and relief. This category may also include such areas as sexual behavior, self-injurious acts, and substance abuse.

Possibilities

Samantha Lynn's entire family suffered from Impulse-Control disorders. No one in the family was ever properly diagnosed due to various factors.

Impulse-Control Disorder Not Otherwise Specified

Timmy takes things from stores that he really doesn't need or want.

Kleptomania

Timmy masturbates himself to the point of exhaustion, passing out in bed with items he steals.

Kleptolagnia

Timmy bites his nails and picks his skin.

Onychotillomania

Robert Jr. loves to set fires, though he does not do so for any financial gain.

Pyromania

Fire Setting

Fire Starter

Robert Sr. has a flash temper. He goes from zero to one hundred at the snap of one's fingers.

Intermittent Explosive Disorder

Road Rage

Episodic Dyscontrol Syndrome

Robert Sr.'s rages came to full fruition during sports events.

Sports Rage

Robert Sr. has a lesion in the hypothalamus that causes his explosive behavior.

Ventromedial Hypothalamic Syndrome

Otis, when working, can't stop working. He takes over time to an extreme.

Workaholism

Otis rarely sleeps due to his extensive computer use.
E-Mail Addiction
Pathological Computer Use Disorder
Internet Addiction

Otis spends the family savings gambling.
Pathological Gambling

SamanthaLynn during her early to mid teens could be found in her bedroom soothing herself by pulling the hair out of her eyelashes and arms.
Trichotillomania

SamanthaLynn during her early to mid teens could be found in her bedroom soothing herself by pulling the hair out of her eyelashes and arms due to a Streptococcal infection.
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

Disorders in this category

E-Mail Addiction
Episodic Dyscontrol Syndrome
Fire Setting
Fire Starter
Impulse-Control Disorder Not Otherwise Specified
Intermittent Explosive Disorder
Internet Addiction
Kleptolagnia
Kleptomania
Onychotillomania
Pathological Computer Use Disorder
Pathological Gambling
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections
Pyromania
Road Rage
Sports Rage
Trichotillomania
Ventromedial Hypothalamic Syndrome
Workaholism
Mental Disorder Due to a General Medical Condition

A Mental Disorder Due to a General Medical Condition is a mental disorder or disorders that may have come about as a direct result of physiological factors leading to psychological problems.

It is at this point in the analysis that I would like to step away from the current approach in dealing with the major categories of the psychiatric disorders. It is important for anyone who is attempting to understand psychiatric diagnosis to properly analyze in the correct order. Therefore the reader should understand and know that before any other psychiatric disorder is evaluated you much always rule out the possibility of a general medical condition. This is the case because without exception all medical conditions can produce what appears to be a psychiatric illness. The clinician who is not attuned to this may jump too quickly and avoid a complete medical workup. The list below represents some of the medical conditions which must be the focus of the analysis of a psychiatric disorder. Again, the individual's psychiatric presentation can be caused as the result of a general medical condition. Learn this lesson now and you will lessen the possibility of the misdiagnosis of the patient.

Disorders in this Category

- Amnestic Disorder Due to a General Medical Condition
- Anxiety Disorder Due to a General Medical Condition
- Aphonia
- Apraxia
- Audiogenic Seizure
- Catatonic Disorder Due to a General Medical Condition
- Clonic Convulsion
- Convulsion
- Delusional Disorder
- Dissociative Disorders Due to a General Medical Condition
- Dostoenvsky Syndrome
- Dysarthria
- Dyskinesia
- Dysstasia
- Hallucinosis
- Intercital Syndrome
- Mental Disorder Not Otherwise Specified
- Mood Disorder Due to a General Medical Condition
- Organic Disorders
- Personality Change Due to a General Medical Condition
- Postconcussional Syndrome
- Postconcussional Syndrome
- Postencephalitic Syndrome
- Psychomotor Epilepsy
- Psychomotor Seizure
- Psychotic Due to a General Medical Condition
- Seizure
- Sexual Dysfunction Due to a General Medical Condition
- Shaken Baby Syndrome
- Sleep Disorder Due to a General Medical Condition
- Temporal Lobe Epilepsy
- Temporal Lobe Seizure
- Temporal Lobe Syndrome
Mood Disorders

Those with Mood Disorders are individuals with mental disorders who have a disturbance of mood. Unlike affect, which is short in duration, mood is more pervasive with an inappropriate, exaggerated, or limited range of feelings. These moods may consist of extreme highs, extreme lows, or a combination of both over time.

Possibilities

Katheryn, her parents, and her brother suffered a great deal from mood disorders. These disorders slipped past their family doctor very easily and had only been noted briefly in their medical history.
Mood Disorder Not Otherwise Specified
Depressive Disorder Not Otherwise Specified

Kathryn and her father suffered from emotional problems that lasted their entire lifetimes.
Dysthymic Disorder

Her father suffered from emotional problems as a result of a change of seasons where he lived.
Seasonal Affective Disorder
Seasonal Mood Disorder

Her father fit criteria for a diagnosis of depression.
Major Depressive Disorder, Recurrent
Major Depressive Disorder, Single Episode

Her father developed a mood disorder after surviving a long internment in a concentration camp, although the origin is not clearly known.
Survivor Syndrome

Her father fit criteria for a disorder related to mental retardation.
Williams Syndrome

Her mother lived her entire teenage and adult life with several mood related problems.
Premenstrual Syndrome, Premenstrual Tension (PMT), Premenstrual Dysphoric Disorder (PMDD), Late Luteal Phase Dysphoric Disorder, Luteal Phase Dysphoric Disorder

Her brother was up one moment and down the next. He was unpredictable and unmanageable.
Bipolar I Disorder, Most Recent Episode Manic, Bipolar I Disorder, Most Recent Episode Hypomanic, Bipolar I Disorder, Most Recent Episode Mixed, Bipolar I Disorder, Most Recent Episode Depressed, Bipolar I Disorder Not Otherwise Specified, Bipolar I Disorder, Single Manic Episode

Her brother was simply described as acting a bit hyper.
**Cyclothymic Disorder**

Her bother paradoxically crashed and remained depressed for unpredictable periods of time.

**Bipolar II Disorder**

**Unipolar Depression**

Her brother began drinking which led to physical problems linked and exacerbated existing mood related problems.

**Mood Disorder Due to a General Medical Condition, Mood Disorder Not Otherwise Specified**

### Disorders in this Category

**Depressive Disorders**

Depressive Disorder Not Otherwise Specified  
Dysthymic Disorder  
Late Luteal Phase Dysphoric Disorder  
Luteal Phase Dysphoric Disorder  
Major Depressive Disorder, Recurrent  
Major Depressive Disorder, Single Episode  
Premenstrual Dysphoric Disorder (PMDD)  
Premenstrual Syndrome  
Premenstrual Tension (PMT)  
Seasonal Affective Disorder  
Seasonal Mood Disorder  
Survivor Syndrome  
Williams Syndrome

**Bipolar Disorder**

Bipolar I Disorder Not Otherwise Specified  
Bipolar I Disorder, Most Recent Episode Depressed  
Bipolar I Disorder, Most Recent Episode Hypomanic  
Bipolar I Disorder, Most Recent Episode Manic  
Bipolar I Disorder, Most Recent Episode Mixed  
Bipolar I Disorder, Single Manic Episode  
Bipolar II Disorder  
Cyclothymic Disorder  
Unipolar Depression

**Other Mood Disorders**

Mood Disorder Due to a General Medical Condition  
Mood Disorder Not Otherwise Specified
Other Conditions That May Be a Focus of Clinical Attention

Other Conditions That May Be a Focus of Clinical Attention is a comprehensive list of mental disorders that are not technically mental disorder. However, these disorders may lead or cause an individual to require psychiatric attention.

In dealing with this case other clinicians decided to consult with Dr. Gary Solomon regarding other conditions that may be of focus of clinical attention. These often overlooked possibilities can be the key to understanding more esoteric clinical problems. The following is the transcript of the recording made during the consultation.

Professor Gary Solomon reported the following: “Ladies and gentleman, it’s going to be important for us to take the time to look at other clinical possibilities. Rather than break them down by through using the individual players in this case, I’ve decided to give you chapter and verse, the various clinical conditions. Get out your pens and papers and please take the following notes.”

Possibilities

It’s completely possible that one of these individuals suffered from problems induced by antidepressants such as lithium or valproate. These problems may cause subtle tremors. Psychological Factor Affecting Medical Condition

If any of those under observation experience muscle rigidity, fever, problems sweating, trouble swallowing, or delirium, they may suffer from Neuroleptic Malignant Syndrome

Some patients will become restless as a result of medication. Neuroleptic-Induced Acute Akathisia

Medications may cause muscles to contract in the head, neck, or other parts of the body. Neuroleptic-Induced Acute Dystonia

Some will appear to have a frozen face, shuffling gate, or pill swallowing tremor. Neuroleptic-Induced Parkinsonism

Others will have odd facial jaw, tongue, and limb movement. Neuroleptic-Induced Tardive Dyskinesia

Some may exhibit spontaneous motor movement and abnormal gesturing. Neuroleptic-Induced Akinesia

While others seem to have an abnormal slowing of bodily movements. Neuroleptic-Induced Bradykinesia
Motor movement problems could exist as a result of extra
Neuroleptic-Induced Extrapyramidal

Rhythmic movements may also be exhibited.
Neuroleptic-Induced Postural Tremor

Fellow clinicians, each of these can be difficult to identify but you can not avoid the suspicion, therefore please note
Medication-Induced Movement Disorder Not Otherwise Specified

Relational problems could exist with a partner.
Partner Relational Problem

Relational problems could exist between siblings.
Sibling Relational Problem

The relational problems could be the result of mental disorders or a general medical condition.
Relational Problem Related to a Mental Disorder or General Medical Condition

If you don’t know what the cause is, but are suspicious of the aforementioned, you will note
Relational Problem Not Otherwise Specified

Problems related to abuse or neglect is not uncommon. The abuse of a baby.
Battered Baby Syndrome

The abuse of a child, wife, or an adult.
Battered Child Syndrome, Battered Wife Syndrome, Physical Abuse of Adult

The abuse of an elder.
Elder Abuse

While some children fail to thrive as a result of poor care, other children may have problems as a result of neglect.
Failure to Thrive (FTT)

Competition between parents may result in alienation on the part of one parent or the other.
Parental Alienation Syndrome

Should both parents walk away from the responsibility of the child causing the child to raise themselves, severe problems may arise.
Feral Child

Some children may experience actual physical abuse.
Physical Abuse of Child

Some children may experience sexual abuse.
Sexual Abuse of Child

Some adults may experience sexual abuse.

Sexual Abuse of Adult

Sexual Abuse

A spouse may also experience abuse, both physical and mental.

Spouse Abuse

There are at least a small group of problems that may exist that can be overlooked, such as academic problems in both children and adults.

Academic Problem

Some may have problems adapting to a new environment.

Acculturation Problem

Adults who act inappropriately by lying, cheating, and stealing may cause extreme disruption in the family and community.

Adult Antisocial Behavior

This may be in the form of attempting to receive compensation by claiming to be ill.

Malingering, Compensation Neurosis, Pathomimesis, Pathomimicry

Similar to this problem, but an exception, comes in the form of seeking medical attention for the sole purpose of being attended to medically.

Factitious Disorder by Proxy

Attention should be given to aging individuals who have a cognitive decline.

Age-Related Cognitive Decline

Should there be a death in the family we would expect grieving to take place.

Bereavement

Some may refuse to follow through with treatment.

Noncompliance With Treatment

Others may report that they simply can not function well in their job.

Occupational Problem

It should be noted that this may be caused as a result of low intellectual functioning.

Borderline Intellectual Functioning

Similarly this could be caused by a shift related to phase of life.

Phase of Life Problem

Finally, those seeking support within religious groups may struggle to find their way.
**Religious or Spiritual Problem**

### Disorders in this Category

#### Psychological Factors Affecting Medical Condition
- Psychological Factor Affecting Medical Condition

#### Medication-Induced Movement Disorders
- Medication-Induced Movement Disorder
- Not Otherwise Specified
- Neuroleptic Malignant Syndrome
- Neuroleptic-Induced Acute Akathisia
- Dystonia
- Neuroleptic-Induced Akinesia
- Neuroleptic-Induced Bradykinesia
- Neuroleptic-Induced Extrapyramidal Neuroleptic-Induced Parkinsonism
- Neuroleptic-Induced Postural Tremor
- Neuroleptic-Induced Tardive
- Dyskinesia

#### Relational Problems
- Partner Relational Problem
- Relational Problem Not Otherwise Specified
- Relational Problem Due to a Mental Disorder or General Medical Condition
- Sibling Relational Problem

### Problems Related to Abuse or Neglect
- Battered Baby Syndrome
- Battered Child Syndrome
- Battered Wife Syndrome
- Elder Abuse
- Factitious Disorder by Proxy
- Failure to Thrive (FTT)
- Feral Child
- Neglect of Child
- Parental Alienation Syndrome
- Physical Abuse of Adult
- Physical Abuse of Child
- Sexual Abuse
- Sexual Abuse of Adult
- Sexual Abuse of Child
- Spouse Abuse

#### Additional Conditions That May Be a Focus of Clinical Attention
- Academic Problem
- Acculturation Problem
- Adult Antisocial Behavior
- Age-Related Cognitive Decline
- Bereavement
- Borderline Intellectual Functioning
- Compensation Neurosis
- Identity Problem
- Malingering
- Noncompliance With Treatment
- Occupational Problem
- Pathomimesis
- Pathomimicry
- Phase of Life Problem
- Religious or Spiritual Problem
Personality Disorders

Those who have Personality Disorders are individuals with mental disorders related to personality problems that are enduring in nature and which play a predominant role in an individual’s life; the disorder is constant. This disorder consists of problems with affects, thoughts, emotions, interpersonal functioning, and impulse control.

SamanthaLynn makes a bit of a hobby of trying to analyze everyone's personality. It is not uncommon for her to sit back in her rocking chair in the front porch of her raggedy house and reflect on all the personalities that have been in and out of her life.

Possibilities

Sometimes SamanthaLynn observes personalities so extreme that it is difficult for her to understand and evaluate them. 
Personality Disorder Not Otherwise Specified

Robert Sr., SamanthaLynn's ex husband, lies, cheats, and steals. He never seems to care much about anybody but himself. 
Antisocial Personality Disorder, Asocial Personality Disorder, Amoral Personality Disorder, Psychopathy, Dissocial Personality Disorder, Personality Disorder With Predominately Sociopathic and Asocial Matifistation, Dissocial Personality Disorder

He has a volatile temper, on one minute and off the next. 
Explosive Personality Disorder
Intermittent Explosive Disorder

He often presents as if he is more than one person at the same time. 
Multiple Personality Disorder

He is commonly cruel to people. 
Sadistic Personality Disorder

Robert Sr. thinks that the world revolves around him and that he should be the complete center of attention. 
Narcissistic Personality Disorder
Compensatory Narcissistic Personality Disorder

His personality changes from time to time, jumping from accepting to giving and every variation in between. 
Borderline Personality Disorder
Emotionally Unstable Personality Disorder

SamanthaLynn views her own personality as being up one moment and down the next.
Cyclothymic Personality Disorder
Affective Personality Disorder

She is filled with insecurity, self-doubt, and incompleteness.
Anankastic Personality Disorder

She admits that she has little capacity to enjoy life, with passive compliance to her elders.
Asthenic Personality Disorder
Inadequate Personality Disorder

She forever avoids dealing with problems and issues related to other people.
Avoidant Personality Disorder
Anxious Personality Disorder

She finds herself relying on others to be who she is on any given day.
Dependent Personality Disorder

Otis, Robert Sr.'s grandfather, had an out blown personality, describing everything to great exaggeration.
Histrionic Personality Disorder
Hysterical Personality Disorder

Otis commonly felt like he was the brute of other people's actions, almost getting pleasure from the way that they treated him.
Masochistic Personality
Masochistic Self-Defeating Personality Disorder

Kathryn acted out her anger on other people when it really related to something else.
Passive-Aggressive Personality Disorder

She was always down and negative about everything that took place in her life.
Self-Defeating Personality Disorder
Negativistic Personality Disorder

She constantly cleaned the house, yet could not throw anything away.
Compulsive Hoarding
Obsessive-Compulsive Personality Disorder

She was restricted in her range of emotion in dealing with interpersonal relationships.
Schizoid Personality Disorder

Officer Abraham prefers to work alone and in isolation. It is rare for him to leave the station.
Schizotypal Personality Disorder

He is paranoid about nearly everything.
Paranoid Personality Disorder

Disorders in this Category

Affective Personality Disorder
Amoral Personality Disorder
Anankastic Personality Disorder
Antisocial Personality Disorder
Anxious Personality Disorder
Asocial Personality Disorder
Asthenic Personality Disorder
Avoidant Personality Disorder
Borderline Personality Disorder
Compensatory Narcissistic Personality Disorder
Compulsive Hoarding
Cyclothymic Personality Disorder
Dependent Personality Disorder
Dissocial Personality Disorder
Emotionally Unstable Personality Disorder
Explosive Personality Disorder
Histrionic Personality Disorder
Hysterical Personality Disorder
Inadequate Personality Disorder
Intermittent Explosive Disorder

Masochistic Personality
Masochistic Self-Defeating Personality Disorder
Multiple Personality Disorder
Narcissistic Personality Disorder
Negativistic Personality Disorder
Obsessive-Compulsive Personality Disorder
Paranoid Personality Disorder
Passive-Aggressive Personality Disorder
Personality Disorder Not Otherwise Specified
Personality Disorder With Predominately Sociopathic and Asocial Matifization
Psychopathy
Sadistic Personality Disorder
Schizoid Personality Disorder
Schizotypal Personality Disorder
Self-Defeating Personality Disorder
Schizophrenia and Other Psychotic Disorders

Schizophrenia and Other Psychotic Disorders consist of individuals with mental disorders who have symptoms of psychosis, delusions or hallucinations. I most disorders of neurosis the individual may know they are not functioning correctly. With Schizophrenia the individual does not know there is a problem; it is in the brain as and internal process verses the external process in the neurosis.

When Officer Gilbert drove away from the home of SamanthaLynn he could not help but feel her pain. He has great disdain for delivering news of this type. It is his least favorite task. Other difficult encounters are with various people in distress. The most difficult of those cases are those suffering from psychotic disorders.

Possibilities

Those who had hallucinations, delusions, and disorganized speech were the worst of the worst cases.

Schizophrenia

If they fell into a stopper with stereotyped movements, either rigid or very flexible, or hyper activity, they suffered from

Schizophrenia Catatonic Type

Possibly the individual didn't meet the criteria for the catatonic type, but had remarkable features of flat affect, disorganized speech and behavior.

Schizophrenia Disorganized Type

Those who had delusions with frequent auditory hallucinations could be the most difficult to work with as they were skeptical of anything officer Gilbert did to try and help them.

Schizophrenia Paranoid Type

He was often saddened to find that a once stable schizophrenic had returned to their prior behavior.

Schizophrenia Residual Type

He had learned early on that if the individual suffering from the psychotic disorder had an active phase for a period of about two weeks was more likely to be

Schizoaffective Disorder
Schizophreniform Disorder

But it seemed more often than clinicians had trouble identifying specific criteria which would classify those with psychotic disorders.

Schizophrenia Undifferentiated Type

He had seen his share of those who had brief psychotic states.

Brief Psychotic Disorder
Again, it was not unusual if the clinicians could not identify the specific criteria to meet the definition of Brief Psychotic Disorder. **Psychotic Disorder Not Otherwise Specified**

Although he was not a clinician, he knew himself that these individuals required a complete medical exam to rule out the possibility of a medical condition causing medical psychotic disorder. **Psychotic Disorder Due to a General Medical Condition**

Officer Gilbert recalled some unusual cases that the doctors tried to explain to him there was the case that Andrew Nessen, who believed that his body was infested with parasites. **Delusional Parasitosis, Delusions of Parasitosis, Ekbom's Syndrome II**

These were all examples of odd delusions created in the mind. **Delusional Disorder**

He remembered Janis Beck who denied that everything existed, even believing that her own body had desinigrated and that she no longer existed. **Cotard's Syndrome, Délire de Dégation, Insanity of Negation**

The Randal family truly surprised him as they all shared the same psychotic belief. **Shared Psychotic Disorder, Folie a Deux, Shared Madness, Induced Delusional Disorder, Shared Paranoid Disorder**

Oddly enough their neighbors, the Johnsons, thought that strangers were family members. **Frégoli Syndrome**

It was just the opposite of the Smiths, who thought that family members changed into somebody else. **Intermetamorphosis**

He hated that he had to draw his taser and fire Linda Kurrkoff who was extremely jealous of everything that her husband did. **Othello Syndrome**

Of course there was the Kuhn family who thought that they were being replaced by body doubles. **Capgras Syndrome, L'illusion De Sosies, Illusion of Doubles**

And how could he forget Tyra Randal who thought that some important people she saw on television were in love with her. **Clérambault's Syndrome, Erotomanic Delusional Disorder**
Disorders in this Category

Brief Psychotic Disorder
Capgras Syndrome
Clérambault's Syndrome
Cotard's Syndrome
Délire de Dégation
Delusional Disorder
Delusional Parasitosis
Delusions of Parasitosis
Ekbomb's Syndrome II
Erotomanic Delusional Disorder
Folie a Deux
Frégoli Syndrome
Illusion of Doubles
Induced Delusional Disorder
Insanity of Negation
Intermetamorphosis
L'illusion De Sosies
Othello Syndrome
Psychotic Disorder Due to a General Medical Condition
Psychotic Disorder Not Otherwise Specified
Schizoaffective Disorder
Schizophrenia
Schizophrenia Catatonic Type
Schizophrenia Disorganized Type
Schizophrenia Paranoid Type
Schizophrenia Residual Type
Schizophrenia Undifferentiated Type
Schizophreniform Disorder
Shared Madness
Shared Paranoid Disorder
Shared Psychotic Disorder
Sexual and Gender Identity Disorders

Those with Sexual and Gender Identity Disorders are individuals with mental disorders related to sexual functioning. The dysfunction consists of a wide range of problems and issues ranging from low sexual desire and sexual arousal to orgasmic problems, pain, and abnormal sexual interests. Additionally, this category contains problems of sexual identity with feelings and beliefs of being the wrong gender; male’s desire to be female and female’s desire to be male.

In attempting to complete the report for this family, nothing became more overwhelming for the psychiatrist than dealing with issues and problems related to sexual identity disorders. Each of them had something. While there are no definitive components to understanding the sexual dysfunctions of the family members, this portion of the evaluation attempts to make some educated guesses.

Possibilities

One member of the family wasn't really interested in having sex, but when they finally did they liked it.
Hypoactive Sexual Desire Disorder

Another member of the family wasn't interested and didn't like it once they had it.
Sexual Aversion Disorder

A couple of female family members had difficulty becoming aroused.
Female Sexual Arousal Disorder

Old man Otis had trouble getting an erection.
Male Erectile Disorder

A couple of times when he did get an erection it wouldn't go away for five or six hours.
Priapism

Kathryn was never able to have an orgasm.
Female Sexual Arousal Disorder

Robert Jr. would sometimes have problems having an orgasm.
Male Orgasmic Disorder

Other times he would have an orgasm too quickly.
Premature Ejaculation

SamanthaLynn had a friend who was always having problems and in pain when engaging in sex.
Dyspareunia
Another friend was never able to have sex because she was in so much pain.

**Vaginismus**

She could never let anything be put in her, including a tampon. This may have been related to a medical condition.

**Sexual Dysfunction Due to a General Medical Condition**

Or not clearly defined enough to warrant a specific diagnosis.

**Sexual Dysfunction Not Otherwise Specified**

Some people get off from just rubbing up against others.

**Frotteurism**

The more abhorrent are those who enjoy having sex with prepubescent children under the age of thirteen.

**Pedophilia**

A few get sexual excitement just by watching people who don't know that they're being watched.

**Voyeurism**

**Peeping Tom**

And of course there are those who get sexual pleasure from exposing themselves to unwitting people.

**Exhibitionism**

When times were good, Robert and Kathryn liked to play games. Kathryn would take a paddle and beat Robert.

**Sexual Sadism**

And Robert really liked it.

**Sexual Masochism**

Both of them enjoyed from time to time being choked to have a more intense orgasm.

**Airwalker's, Auto-Erotic Asphyxiation, Autoerotic Asphyxiation, Breath Games, Breath Play, Choke Chicks, Erotic Asphyxiation, Gaspers, Scarfing**

Although they didn't know it this was all pretty dangerous stuff.

**Hypoxyphilia**

If you add in some of the other things they used to do, well, things really got out of hand. Sometimes they got pleasure playing with fecal matter while having sex.

**Scatting, Coprophilia, Undinism, Urolognia, Golden Showers**

Everybody in the family, and all of SamanthaLynn's friends enjoyed playing with sexual toys like dildos and vibrators, though some would confuse that with something known as
Fetishism

It was nothing for Tim and Robert Jr. to get a lot of pleasure from looking at naked people. Scopophilia, Scoptophilia

They both got a kick out of looking up girls dresses. Upskirting

A couple of times Timmy was caught in the field trying to have sex with the family dog. Zooerasty, Katasexualism, Bestiality

No one SamanthaLynn knew of tried having sex with someone dead. Necrophilia, Katasexualism

Some of these disorders may have been the result of infantile conflicts. Actual Neurosis

For instance: Wanting to have sex with an amputee. Acrotomorphilia, Monopede Mania, Monopedophilia, Unipedophilia

Possibly being an amputee for sexual purposes. Apotemnophilia

Women who just want to make men feel helpless sexually. Delilah Syndrome

Men, who want sex with other men, but refuse to think of it as being gay or homosexual. Down Low

There are those who like being in filth or filthy surroundings. Mysophilia

And others liked it just for the smell. Osphresiolagnia

Others like to steal for sexual purposes. Kleptolagnia

A few liked having animals. Klysmaphilia

When SamanthaLynn's friends had dry spells in their dating life they would just have sex with their friends. Friends with Benefits
All of the aforementioned could be caused by a brain disorder. 
*Klüver–Bucy Syndrome*

By the way, did I mention that there are some that like to hear people talk dirty sex talk? 
*Ecouteur*

While others like to make random telephone calls and say sexual things that people don't want to hear. 
*Telephone Scatalogia*

Some women want to have sex with more than one partner. 
*Nymphomania*

Getting all these diagnosed is just a damn mess, but everyone at some time suffers from some sexual disorder. 
*Sexual Disorder Not Otherwise Specified*

On one occasion, while Otis was in the service, he met a man who just wasn't sure he was a man. 
*Gender Identity Disorder*

Sometimes Otis's father could be found dancing around the house in his wife's underwear and dresses. 
*Transvestic Fetishism*  
*Dual-Role Transvestism Fetishistic*

Everybody thought the whole situation was confusing, but no one knew what to say. 
*Gender Identity Disorder Not Otherwise Specified*

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**Disorders in this Category**

**Sexual Desire Disorders**

- Hypoactive Sexual Desire Disorder
- Sexual Aversion Disorder

**Sexual Desire Disorders**

- Female Sexual Arousal Disorder
- Male Erectile Disorder
- Priapism

**Orgasmic Disorders**

- Female Orgasmic Disorder

**Sexual Aversion Disorder**

- Male Orgasmic Disorder
- Premature Ejaculation

**Premature Ejaculation**

**Sexual Pain Disorders**

- Dyspareunia
- Vaginismus
- Sexual Dysfunction Due to a General Medical Condition
- Sexual Dysfunction Not Otherwise Specified
Paraphilias

Acrotomorphilia
Actual Neurosis
Airwalker’s
Apotemnophilia
Auto-Erotic Asphyxiation
Autoerotic Asphyxiation
Breath Games
Breath Play
Bestiality
Choke Chicks
Coprophilia
Delilah Syndrome
Down Low
Dual-Role Transvestism
Fetishistic
Ecouteur
Erotic Asphyxiation
Exhibitionism
Fetishism
Friends with Benefits
Frotteurism
Gaspers
Golden Showers
Hypoxphilia
Katasexualism
Kleptolagnia
Klysmaphilia
Klüber–Bucy Syndrome
Monoped Mania
Monopedophilia
Mysophilia

Necrophilia
Nymphomania
Osphresiolagnia
Paraphilia Not Otherwise Specified
Pedophilia
Peeping Tom
Scopophilia
Scarfing
Scatting
Scatting
Scopophilia
Sexual Masochism
Sexual Disorder Not Otherwise Specified
Sexual Sadism
Telephone Scatalogia
Transvestism
Transvestic Fetishism
Undinism
Unipedophilia
Upskirting
Uurolagnia
Voyeurism
Zooerasty

Gender Identity Disorder

Gender Identity Disorder
Gender Identity Disorder Not Otherwise Specified
Sexual Disorder Not Otherwise Specified
Specified
Sleep Disorders

Sleep Disorders consist of individuals with mental disorders related to problems with sleep. There are two subgroups: Dyssomnias, characterized by the amount, quality, or timing of sleep; initiating, maintaining or excessive sleepiness and, Parasomnias, characterized by the activation of the autonomic nervous system, motor system, or cognitive process required during sleep or the transition from sleep to waking.

Right next to the police station, where officer Gilbert headed up his team of officers, was the fire station. These men and women suffered from sleep problems that he had never even heard of.

Possibilities

Some of the firefighters couldn't stay asleep.
Primary Insomnia

Others slept too much.
Primary Hypersomnia

A few of them had issues that caused sleep problems as a result of fellow fire fighters being hurt or losing their lives when they were untouched.
Survivor Syndrome

More than one of them had problems associated with their breathing while sleeping, which caused them to wake up.
Sleep Apnea, Breathing-Related Sleep Disorder

Sometimes these problems are caused by the environment.
Circadian Rhythm Sleep Disorder

A few of these people had problems sleeping since birth related to their breathing patterns.
Ondine's Curse

For those who couldn't get to sleep and ultimately had problems waking up, sleep was forever a complication.
Delayed Sleep-Phase Syndrome

One of the women at least a hundred pounds overweight had problems sleeping as a result of her weight.
Central Alveolar Hypoventilation Syndrome

When she did sleep, it would last for twenty hours or more. This disorder related to her overeating, weight gain, irritability, and inappropriate sexual behavior.
Kleine-Levine Syndrome
One of the men who used to drive the fire truck seemed to fall asleep for no reason at all.

Narcolepsy
Disorder of Excessive Somnolence

All of the aforementioned, Officer Gilbert learned, are types of insomnias, some of which do not have as clear a presentation and diagnosis.

Dyssomnia Not Otherwise Specified

As a result of Officer Gilbert's attempt to learn more about sleep problems, he learned of another category; the Parasomnias. Some of the firefighters had bad dreams, plagued with waking up in the middle of the night or at odd hours, crying out loud.

Nightmare Disorder, Night Terrors Disorders, Pavor Nocturnus, Sleep Terror Disorder, Dream Anxiety Disorder

At least one of the firemen had these problems during the day.

Pavor Diurnus

Although finding a fireman walking around while they were asleep was uncommon, it was not unheard of.

Sleepwalking Disorder

As a result of an obstruction in the upper airway, loud snoring would occur in those who suffered from

Central Sleep Apnea
Obstructive Sleep Apnea

A couple of them would keep others awake when they grinded their teeth in their sleep.

Bruxism

Like the Dyssomnias, Officer Gilbert found that not all sleep related problems can be easily diagnosed

Parasomnia Not Otherwise Specified

Some sleep disorders are caused by medical problems.

Other Sleep Disorders Due to a General Medical Condition

As a result of his reading, he found that sleep disorders can be caused by other mental disorders.

Hypersonnia Related to Another Mental Disorder

He himself had problems falling into a state of REM and would occasionally jump out of bed, screaming and yelling at his wife.

REM Behavior Disorder
Disorders in this Category

Dyssomnias

Breathing-Related Sleep Disorder
Central Alveolar Hypoventilation Syndrome
Circadian Rhythm Sleep Disorder
Delayed Sleep-Phase Syndrome
Disorder of Excessive Somnolence
Dyssomnia Not Otherwise Specified
Kleine-Levine Syndrome
Narcolepsy
Ondine's Curse
Primary Hypersomnia
Primary Insomnia
Sleep Apnea
Survivor Syndrome

Parasomnias

Bruxism
Central Alveolar Hypoventilation Syndrome
Central Sleep Apnea
Dream Anxiety Disorder
Night Terrors Disorders
Nightmare Disorder
Obstructive Sleep Apnea
Parasomnia Not Otherwise Specified
Pavor Diurnus
Pavor Nocturnus
Sleep Terror Disorder
Sleepwalking Disorder
Survivor Syndrome

Sleep Disorders Related to Another Mental Disorder

Hypersomnia Related to Another Mental Disorder
REM Behavior Disorder

Other Sleep Disorders

Other Sleep Disorders Due to a General Medical Condition
Somatoform Disorders

Those with Somatoform Disorders are individuals with mental disorders related to somatic symptoms, also referred to as Psychosomatic. Individuals with these disorders report symptoms of a general medical condition, but there is no evidence of any diagnosable physical problem. These physical problems are sometimes referred to as idiopathic and are not produced intentionally. The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning.

Michelle, one of SamanthaLynn's best friends, was able to supply a great deal of information to the clinicians who did the evaluations. In a dicussion with her, Michelle related a laundry list of problems that SamanthaLynn's friends had. It's important to note that the clinician realized immediately that these problems, although physical in nature, were all in the mind. Not one of them could be recognized as a true physical illness. Medical examinations of SamanthaLynn's friends would have revealed that each complaint culminated with the medical community believing that the physical problems were idiopathic in nature.

Possibilities

Maria is constantly tired and cannot last through an entire day. 
**Chronic Fatigue Syndrome**, **Myalgic Encephalomyelitis**, **Postviral Syndrome**, **Neurasthenia**, **Fibromyalgia Syndrome**, **Asthenia**

Maria complains of headaches, memory loss, insomnia, and depression and spent time in the armed forces in the Gulf War 
**Gulf War Syndrome**

Renee thinks she’s pregnant though tests reveal that she is not. 
**Pseudocyesis Disorder**

She cannot stop moving her legs when lying down or sitting in a chair. 
**Wittmaack-Ekbom's Syndrome**  
**Restless Legs Syndrome**

Jeremy is attending medical school. He seems to have whatever condition he is studying that week. 
**Medical Student Syndrome**  
**Medical Student Hypochondria**

The worst of his problems is constant abdominal pain, constipation, and/or diarrhea. 
**Irritable Bowel Syndrome**

It is common for him to report multiple complaints in at least four different parts of his body. 
**Somatization Disorder**
Occasionally it is just one or two locations.

Pain Disorder

Oddly enough, on two occasions he was seriously injured, yet he acted as if he cared less.

La Belle Indifférence

Betty seems to always have problems related to her auto immune system, causing inflammation of various body tissues.

Lupus

She suffers from emotional instability, repression, physical symptoms and dissociation.

Hysteria, Hysteria Neurasthenia, Hypnoid Hysteria

Marleen has major problems related to her digestive tract. Specifically, in the lining of the large intestines.

Colitis Ulcerative

So severe are her problems that she often feels like she is in another place or another time.

Conversion Disorder
Conversion Hysteria

Additional complications have risen as a result of her inability to see her body as it truly is.

Body Dysmorphic Disorder
Dysmorphobia

She seems to have the disease of the day, always complaining that she is sick with something.

Hypochondriasis Disorder

As of late, most doctors are unable to separate one illness from the other and identify any cause.

Undifferentiated Somatoform Disorder
Somatoform Disorder Not Otherwise Specified
Briquet's Syndrome
Disorders in this Category

Asthenia
Body Dysmorphic Disorder
Briquet’s Syndrome
Chronic Fatigue Syndrome
Colitis Ulcerative
Conversion Disorder
Conversion Hysteria
Dysmorphobía
Fibromyalgia Syndrome
Gulf War Syndrome
Hypnoid Hysteria
Hypochondriasis Disorder
Hysteria
Hysteria Neurasthenia
Irritable Bowel Syndrome
La Belle Indifférence
Lupus
Medical Student Hypochondria
Medical Student Syndrome
Myalgic Encephalomyelitis
Neurasthenia
Pain Disorder
Postviral Syndrome
Pseudocyesis Disorder
Restless Legs Syndrome
Somatization Disorder
Somatoform Disorder Not Otherwise Specified
Temporomandibular Joint Syndrome
Undifferentiated Somatoform Disorder
Wittmaack-Ekbom’s Syndrome
**Substance-Related Disorders**

Those with Substance-Related Disorders are individuals with mental disorders related to problems of abnormal use of prescription and non-prescription body and mind altering substances. Each major substance category consists of two subcategories: Use Disorders and Induced Disorders. Most of the subcategories consist of Dependence, Abuse, Intoxication, and Withdrawal.

After the fire subsided and people had ended their curiosity, crews were sent in to clean up the property. Under a pile of burnt rubble one of the crew found a locked metal box which had stayed the heat of the fire. Once the box had been pried open and the contents were unraveled a most interesting diary had been discovered.

Apparently Robert had been court ordered to attend support group meetings for alcohol and drugs. When Robert would come home and share the stories with SamanthaLynn she would write them down in her diary. The notations were simple but quite to the point.

**Possibilities**

Robert suffered from alcohol related disorders

Mary dealt with problems with amphetamines

The entire group suffered from caffeine related disorders

Tom and Rosemary dealt with Cannibalism related disorders.

Joshua was a cocaine user.

Allison used hallucinogens.

Rosemary, Jonathan, and Dexter suffered from inhalant related disorders.

Robin, along with almost every other member of the group, dealt with nicotine related disorders.

The leader of the group, Andrea, admitted quite openly to dealing to opioids related disorders phencyclidine related disorders.

Occasionally there were those whose names were not remembered by Robert, who used sedatives, hypnotics, and anxiolytic related disorders.

Robert's stories that he shared with SamanthaLynn made it clear to her that most of the members used more than one substance.

Poly-substance Related Disorder.

Occasionally he would use the name of a substance that SamanthaLynn had never heard of.
Other Substance Related Disorders.

Sometimes Michelle and others would attend the meetings and not have a clear idea of what they were suffering from.
Substance Disorder Not Otherwise Specified.

### Disorders in this Category

#### Alcohol-Related Disorders

**Alcohol Use Disorders**
- Alcohol Dependence
- Alcohol Abuse

**Alcohol-Induced Disorders**
- Alcohol Intoxication
- Alcohol Withdrawal
- Alcohol Intoxication Delirium
- Alcohol Withdrawal Delirium
- Alcohol-Induced Persisting Dementia
- Alcohol-Induced Persisting Amnestic Disorder
- Alcohol-Induced Psychotic Disorder, With Delusions
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Alcohol-Induced Psychotic Disorder, With Hallucinations
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Alcohol-Induced Mood Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Alcohol-Induced Anxiety Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Alcohol-Induced Sexual Dysfunction
  - With Onset During Intoxication
- Alcohol-Induced Sleep Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Alcohol-Related Disorder Not Otherwise Specified

#### Amphetamine (Or Amphetamine-Like Substance)-Related Disorders

**Amphetamine Use Disorders**
- Amphetamine Dependence
- Amphetamine Abuse

**Amphetamine-Induced Disorders**
- Amphetamine Intoxication
- Amphetamine Withdrawal
- Amphetamine Intoxication Delirium
- Amphetamine-Induced Psychotic Disorder, With Delusions
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Amphetamine-Induced Psychotic Disorder, With Hallucinations
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Amphetamine-Induced Mood Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Amphetamine-Induced Anxiety Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Amphetamine-Induced Sexual Dysfunction
  - With Onset During Intoxication
- Amphetamine-Induced Sleep Disorder
  - With Onset During Intoxication
  - With Onset During Withdrawal
- Amphetamine-Related Disorder Not Otherwise Specified
Caffeine-Related Disorders

Caffeine-Induced Disorders

- Caffeine Intoxication
- Caffeine-Induced Anxiety Disorder *With Onset During Intoxication*
- Caffeine-Induced Sleep Disorder *With Onset During Intoxication*
- Caffeine-Related Disorder Not Otherwise Specified

Cannabis-Related Disorders

Cannabis Use Disorders

- Cannabis Dependence
- Cannabis Abuse

Cannabis-Induced Disorders

- Cannabis Intoxication
- Cannabis Intoxication Delirium
- Cannabis-Induced Psychotic Disorder, With Delusions *With Onset During Intoxication*
- Cannabis-Induced Psychotic Disorder, With Hallucinations *With Onset During Intoxication*
- Cannabis-Induced Anxiety Disorder *With Onset During Intoxication*
- Cannabis-Induced Disorder Not Otherwise Specified

Cocaine-Related Disorders

Cocaine Use Disorders

- Cocaine Dependence
- Cocaine Abuse

Cocaine-Induced Disorders

- Cocaine Intoxication
- Cocaine Withdrawal
- Cocaine Intoxication Delirium
- Cocaine-Induced Psychotic Disorder, With Delusions *With Onset During Intoxication*
- Cocaine-Induced Psychotic Disorder, With Hallucinations *With Onset During Intoxication*
- Cocaine-Induced Mood Disorder *With Onset During Intoxication*
- Cocaine-Induced Disorder Not Otherwise Specified

Hallucinogen-Related Disorders

Hallucinogen Use Disorders

- Hallucinogen Dependence
- Hallucinogen Abuse

Hallucinogen-Induced Disorders

- Hallucinogen Intoxication
- Hallucinogen Persisting Perception Disorder
- Hallucinogen Intoxication Delirium
- Hallucinogen-Induced Psychotic Disorder, With Delusions *With Onset During Intoxication*
- Hallucinogen-Induced Psychotic Disorder, With Hallucinations *With Onset During Intoxication*
- Hallucinogen-Induced Mood Disorder *With Onset During Intoxication*
- Hallucinogen-Induced Anxiety Disorder *With Onset During Intoxication*
- Hallucinogen-Related Disorder Not Otherwise Specified
Inhalants-Related Disorders

Inhalants Use Disorders

Inhalant Dependence
Inhalant Abuse

Inhalants-Induced Disorders

Inhalant Intoxication
Inhalant Intoxication Delirium
Inhalant-Induced Persisting Dementia
Inhalant-Induced Psychotic Disorder, With Delusions
   With Onset During Intoxication
Inhalant-Induced Psychotic Disorder, With Hallucinations
   With Onset During Intoxication
Inhalant-Induced Mood Disorder
   With Onset During Intoxication
Inhalant-Induced Anxiety Disorder
   With Onset During Intoxication
Inhalant-Related Disorder Not Otherwise Specified

Nicotine-Related Disorders

Nicotine Use Disorders

Nicotine Dependence

Nicotine-Induced Disorders

Nicotine Withdrawal

Opioids-Related Disorders

Opioids Use Disorders

Opioids Dependence
Opioids Abuse

Opioids-Induced Disorders

Opioids Intoxication
Opioids Withdrawal

Opioid Intoxication Delirium
   With Onset During Intoxication
Opioid-Induced Psychotic Disorder, With Delusions
   With Onset During Intoxication
Opioid-Induced Psychotic Disorder, With Hallucinations
   With Onset During Intoxication
Opioid-Induced Mood Disorder
   With Onset During Intoxication
Opioid-Induced Sexual Dysfunction
   With Onset During Intoxication
Opioid-Induced Sleep Disorder
Opioid-Related Disorder Not Otherwise Specified

Phencyclidine-Related Disorders

Phencyclidine Use Disorder

Phencyclidine Dependence
Phencyclidine Abuse

Phencyclidine-Induced Disorder

Phencyclidine Intoxication
Phencyclidine Intoxication Delirium
Phencyclidine-Induced Psychotic Disorder, With Delusions
   With Onset During Intoxication
Phencyclidine-Induced Psychotic Disorder, With Hallucinations
   With Onset During Intoxication
Phencyclidine-Induced Mood Disorder
   With Onset During Intoxication
Phencyclidine-Induced Anxiety Disorder
   With Onset During Intoxication
Phencyclidine-Related Disorder Not Otherwise Specified

Sedative-, Hypnotic-, or Anxiolytic-Related Disorders

Sedative, Hypnotic, or Anxiolytic Use Disorders
Sedative, Hypnotics, or Anxiolytic Dependence
Sedative, Hypnotics, or Anxiolytic Abuse

**Sedative, Hypnotic, or Anxiolytic Induced Disorders**

Sedative, Hypnotics, or Anxiolytic Intoxication
Sedative, Hypnotics, or Anxiolytic Withdrawal
Sedative, Hypnotic, or Anxiolytic Intoxication Delirium
Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium
Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia
Sedative, Hypnotic, or Anxiolytic Persisting Amnestic Disorder
Sedative-, Hypnotic, or Anxiolytic-Induced Psychotic Disorder, With Delusions
*With Onset During Intoxication*
*With Onset During Withdrawal*
Sedative-, Hypnotic, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations
*With Onset During Intoxication*
*With Onset During Withdrawal*
Sedative-, Hypnotic, or Anxiolytic-Induced Mood Disorder
*With Onset During Intoxication*
*With Onset During Withdrawal*
Sedative-, Hypnotic, or Anxiolytic-Induced Anxiety Disorder
*With Onset During Intoxication*
*With Onset During Withdrawal*
Sedative-, Hypnotic, or Anxiolytic-Induced Sexual Dysfunction
*With Onset During Intoxication*
Sedative-, Hypnotic, or Anxiolytic-Induced Sleep Disorder
*With Onset During Intoxication*
*With Onset During Withdrawal*
Sedative-, Hypnotic, or Anxiolytic-Related Disorder Not Otherwise Specified

**Polysubstance Use Disorder**

Polysubstance Dependence

**Other (or Unknown) Substance Related Disorders**

**Other (or Unknown) Substance Use Disorders**

Other (or Unknown) Substance Dependence
Other (or Unknown) Substance Abuse

**Other (or Unknown) Substance-Induced Disorders**

Other (or Unknown) Substance Intoxication
Other (or Unknown) Substance Withdrawal
Other (or Unknown) Substance-Induced Delirium
Other (or Unknown) Substance-Induced Persisting Amnestic (Pg. 425; 295)
Other (or Unknown) Substance-Induced Psychotic Disorder, With Delusions
*With Onset During Intoxication*
*With Onset During Withdrawal*
Other (or Unknown) Substance-Induced Mood Disorder
*With Onset During Intoxication*
*With Onset During Withdrawal*
Other (or Unknown) Substance-Induced Anxiety Disorder
*With Onset During Intoxication*
*With Onset During Withdrawal*
Other (or Unknown) Substance-Induced Sexual Dysfunction
*With Onset During Intoxication*
*With Onset During Withdrawal*
Other (or Unknown) Substance-Induced Sleep Disorder
*With Onset During Intoxication*
**With Onset During Withdrawal**
Other (or Unknown) Substance-Related Disorder Not Otherwise Specified
Substance Disorder Not Otherwise Specified
Abstinence Syndrome
Adipsia

<table>
<thead>
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<th>Alcohol Amnestic Disorder</th>
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<tr>
<td>Anabolic-Androgenic Steroids</td>
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<td>Korsakoff’s Syndrome</td>
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<td>Pathological Intoxication</td>
</tr>
<tr>
<td>Polydipsia</td>
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<tr>
<td>Street Name</td>
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</table>
Psychiatric Disorders

Here are some important points to remember when reading through the Alphabetical Listing of Disorders. For more detailed information reread the introduction of the *A Psychiatric Diagnostic Primer*.

**Name**: name of the disorder

*Note*: The word ‘Disorder’ has been omitted from the name of the disorder. Assume that the word ‘Disorder’ is part of the name when looking for a diagnosis.

**Code Number**: ICD 9 Codes: technical, worldwide nomenclature.

**Category**: group classification of the individual disorder.

**Behavioral Presentation** easy to read behavioral presentations.

*Note*: You should assume that most diagnoses also consist of the following:

Symptoms cause clinically important distress or impairment in work, school, social, or personal functioning.

You must always consider this criterion as part of your understanding of any diagnosis under investigation.

**Specifiers, Codes, and Comments**: more information and word origins.

*Note*: Volume of content will vary from diagnosis to diagnosis.

**Degree of Impairment**: level of life or societal impact or impairment.

**Suggested Course of Action**: possible non-pharmaceutical treatment.

**Psychopharmacology**: chemically based and natural interventions.

*Note*: You should not take or recommend any substance, including natural substances, without the supervision of a qualified medical professional.

**Alternate Diagnostic Presentation** other possible disorders.

*Note*: You should assume that most diagnoses may have the possible alternate diagnosis of:

General Medical Condition and/or Substance-Related Disorders.

You must always consider this criterion as part of your understanding of any diagnosis under investigation.

**Internet Resources** specific Internet Resources discussing the disorder.

*Note*: I am in no way endorsing or supporting any of the products advertised on any of the Internet Resources referenced in the book.
# ACADEMIC PROBLEM

**Code Number:** V62.3  
**Category:** Other Conditions That May Be a Focus of Clinical Attention

## Behavioral Presentation
Problems with school and scholastic endeavors.

## Specifiers, Codes and Comments

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</table>

## Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

## Learning Disorder

## Internet Resources
- [http://www.extension.umn.edu/info-u/families/BE826.html](http://www.extension.umn.edu/info-u/families/BE826.html)  
- [http://kidshealth.org/parent/positive/learning/iep.html](http://kidshealth.org/parent/positive/learning/iep.html)  
ACCULTURATION PROBLEM

Code Number: V62.4

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Problems moving from one culture to another as may be the case with immigrants and migrants.

Specifiers, Codes and Comments

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Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Internet Resources
http://www.missionarycare.com/reentry6.htm
http://www.findarticles.com/p/articles/mi_m0902/is_3_30/ai_86874935
http://www.ac.wwu.edu/~culture/rudmin.htm
ACUTE STRESS

**Code Number:** 308.3  
**Category:** Anxiety

**Behavioral Presentation**
- Witnessed or directly experienced both: an actual or threatened death, physical injury to self or others, and felt intense fear, horror, or helplessness.
- *One or more of the following:* relives the events in 1) distressing dreams; 2) thoughts or recollections; 3) flashbacks, hallucinations, or illusions; 4) mental distress resulting from internal or external cues; 5) physical reaction to the internal or external cues.
- *Three or more of the following:* 1) avoids feelings, thoughts, or conversations related to the event; 2) avoids activities, people, or places related to the event; 3) cannot recall important features of event; 4) loss of interest in activities important to the individual; 5) feels detached and isolated; 6) restricted emotions of love and feelings; 7) feels life will be brief and unfulfilling.
- *Three or more of the following during or after the event:* 1) numbing, detachment, or absence of emotional responsiveness; 2) less aware of surroundings; 3) Derealization 4) Depersonalization 5) Disorder of Written Expression.
- Hyper-arousal such as: 1) Insomnia 2) angry outbursts and irritability; 3) poor concentration; 4) hypervigilance; 5) easily startled.
- Must exist for 1 to 30 days.

**Specifiers, Codes and Comments**
- If symptoms last longer than 30 days see: Posttraumatic Stress Disorder
- Studies suggest that approximately 14% to 33% of those exposed to severe trauma may suffer from Acute Stress Disorder.
- From Latin – *acutus*, sharpened; *acuere*, to sharpen; *acus*, a needle.

**Degree of Impairment**
- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

**Suggested Course of Action**
- *Medical Attention*  
- *Therapy/Counseling*  
- *Support Group*  
- *Special Needs*  
- *Change of Location*  
- *Time off*  

**Psychopharmacology**
- *Medications*  
- *Natural Substance*  

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Adjustment Disorder  
- Brief Psychotic Disorder  
- Histrionic Disorder  
- Hypochondriasis Disorder  
- Major Depressive Episode  
- Malingering  
- Obsessive-Compulsive Disorder

*Warning:* Medications and natural substances should be used with a doctor’s approval.
Posttraumatic Stress Disorder
Psychotic Disorder
Schizoid Personality Disorder

Internet Resources
http://www.behavenet.com/capsules/disorders/asd.htm
http://www.healthatoz.com/healthatoz/Atoz/ency/acute_stress_disorder.jsp
http://www.chclibrary.org/micromed/00036170.html
ADJUSTMENT

Code Number: None
Category: Adjustment

Behavioral Presentation
- Over a three month period, as a result of a stressor, individual has symptoms that are emotional and behavioral.
- One of the following: 1) distress beyond what would be expected from the stressor or 2) significant job, academic, or social impairment.
- Symptoms do not last longer than six months.
- Are not the result of a declining Axis I or II disorder nor fulfill an Axis I disorder.

Specifiers, Codes and Comments

- with Anxiety – fearful, nervous, worried, anxious, edgy (Cod–309.24).
- with Depressed Mood – hopeless, tearful, sad, disconsolate, nihilistic (Code–309.0).
- with Disturbance of Conduct – does not follow rules, violates other’s rights, does not maintain social guidelines (Code–309.3).
- with Mixed Anxiety and Depressed Mood – both Anxiety and Depressed Mood (Code–309.28).
- with Mixed Disturbance of Emotions and Conduct – both conduct and emotional problems (Code–309.4).

Unspecified – problems that are social, physical, job related, personal, etc. (Code–309.9).

Acute – symptoms last less than six months.

Chronic – symptoms last for six months or more.

Studies suggest that from as low as approximately 2% in children to as high as approximately 50% in some populations such as heart surgery patients may suffer from Adjustment Disorder.

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | Medical Attention | Medications
Mild | | Natural Substance
Mild to Moderate | | None Suggested
Moderate | | Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe | | 
Severe | | 

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Acute Stress Disorder
Bereavement Disorder
Bipolar I Disorder
Dysthymic Disorder
Major Depressive Episode
Posttraumatic Stress Disorder
Personality Disorder
Internet Resources
http://www.healthcentral.com/mhc/top/000932.cfm
http://mental-disorders.affinityzone.com/adjustment.htm
http://www.mentalhealth.com/rx/p23-aj01.html
http://www.defenseinformationcenter.com/pages/iiehcsb5.html
## ADULT ANTISOCIAL BEHAVIOR

**Code Number:** V71.02  
**Category:** *Other Conditions That May Be a Focus of Clinical Attention*

### Behavioral Presentation

Behavior is not due to a mental disorder.

### Specifiers, Codes and Comments

This category includes groups such as those who deal in illegal substances, knowingly sells stolen goods, cons others out of money and/or goods, etc.

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</table>

### Alternate Diagnostic Presentation

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Antisocial Personality Disorder
- Conduct Disorder
- Impulse-Control. Disorder

### Internet Resources

- [http://www.annalsnyas.org/cgi/content/abstract/931/1/84](http://www.annalsnyas.org/cgi/content/abstract/931/1/84)
- [http://psychcentral.com/disorders/sx7t.htm](http://psychcentral.com/disorders/sx7t.htm)
AGE-RELATED COGNITIVE DECLINE

Code Number: 780.9          Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation

Suffers from a decline in cognitive functioning as might be expected in the aging process.

Specifiers, Codes and Comments

Degree of Impairment   Suggested Course of Action   Psychopharmacology
Very Mild             ¥ Medical Attention           Medications
Mild                  ¥ Therapy/Counseling       Natural Substance
Mild to Moderate      ¥ Support Group              ¥ None Suggested
Moderate              ¥ Special Needs           ¥ Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe    ¥ Change of Location
Severe                ¥ Time off

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Dementia of the Alzheimer’s Type

Internet Resources
http://www.vitacost.com/science/hn/Concern/ARCD.htm
http://www.mothernature.com/Library/Ency/Index.cfm/id/1011007
http://www.uhseast.com/115967.cfm
http://bjp.rcpsych.org/cgi/content/abstract/171/5/449
AGORAPHOBIA

Code Number: None

Category: Anxiety

Behavioral Presentation

- Anxious about a place or situation from which one or both occur: 1) escape could be difficult or embarrassing; 2) if a panic attack occurs help might not be available.
- Avoids situations or places, or endures the situation with material stress, or requires a companion when in the situation.

Specifiers, Codes and Comments

- Examples of situations consist of, but are not limited to, theaters, crowds, staying home, bridges, traveling by bus, train or cars, crowded supermarkets, etc.
- Studies suggest that approximately 95% of those who present with Agoraphobia may have a history of Panic Disorder.
- From Greek – agora, a market-place; phobos, fear; -ia indicating a condition or quality.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
  - Moderate
  - Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Delusional Disorder
Generalized Anxiety Disorder
Malingering
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Psychotic Disorder
Separation Anxiety Disorder
Social Phobia
Specific Phobia

Internet Resources

http://www.psychologyinfo.com/problems/agoraphobia.html
http://familydoctor.org/137.xml
http://www.paniccure.com/
AGORAPHOBIA WITHOUT HISTORY OF PANIC

Code Number: 300.22  
Category: Anxiety

Behavioral Presentation

- Fear of being anxious about a place or situation where escape could be difficult or embarrassing.
- Fear that if a panic attack occurs help might not be available.
- Fear that they will need to avoid situations or places, or endure them but with material stress, or require a companion when in the situation.

Specifiers, Codes and Comments

- Agoraphobia without History of Panic is a part of a subgroup of Panic and Agoraphobia.
- Examples of situations consist of, but are not limited to, theaters, crowds, staying home, bridges, traveling by bus, train or cars, crowded supermarkets, etc.
- Studies suggest that approximately 95% of those who present with Agoraphobia may have a history of Panic Disorder.
- From Greek – agora a market-place; phobos – fear; -ia indicating a condition or quality

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Delusional Disorder
Malingering
Obsessive-Compulsive Disorder
Posttraumatic Stress Disorder
Psychotic Disorder
Separation Anxiety Disorder
Social Phobia
Specific Phobia

Internet Resources

http://www.mentalhealth.com/dis1/p21-an02.html
http://www.psyweb.com/Mdisord/AnxietyDis/agorwopd.jsp
http://ajp.psychiatryonline.org/cgi/content/abstract/152/10/1438

ALCOHOL ABUSE
Behavioral Presentation

- Over one twelve-month period alcohol intake causes clinical distress and impairment.
- *One or more of the following within a twelve-month period:* 1) affects work, social, and leisure functioning; 2) continues to use alcohol in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of alcohol; 5) alcohol abuse leads to legal problems.

Specifiers, Codes and Comments

- Alcohol Abuse is part of the subgroup of Alcohol Use Disorders.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Alcohol Intoxication
Alcohol Dependence
Alcohol Withdrawal
Generalized Anxiety Disorder
Delirium
Mood Disorder
Substance-Induced Persisting Dementia
Persisting Amnestic Disorder
Persisting Dementia
Psychotic Disorder
Sexual Dysfunction
Sleep Disorder

Internet Resources

- [http://ub-counseling.buffalo.edu/alcohol.shtml](http://ub-counseling.buffalo.edu/alcohol.shtml)
- [http://www.agingincanada.ca/Seniors%20Alcohol/1e6.htm](http://www.agingincanada.ca/Seniors%20Alcohol/1e6.htm)
ALCOHOL DEPENDENCE

Code Number: 303.90

Category: Substance-Related

Behavioral Presentation

Over one twelve-month period alcohol intake causes clinical distress and impairment.

*Three or more of the following within a twelve-month period:*
1) more alcohol is needed for the same effect or; 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using, and recovering from the effects of alcohol; 7) affects work, social, and leisure functioning; 8) continues to use an alcohol in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

*With Physiological Dependence* – evidence of tolerance or withdrawal.

*Without Physiological Dependence* – no evidence of tolerance or withdrawal.

*Early Full Remission* – for a period of one to twelve months does not meet criteria for Abuse or Dependence.

*Early Partial Remission* – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.

*Sustained Full Remission* – for twelve months or longer does not meet criteria for Abuse or Dependence.

*Sustained Partial Remission* – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.

*On Agonist Therapy* – on prescribed agonist medication.

*In a Controlled Environment* – is in a controlled environment; hospital or inpatient clinic.

Alcohol Dependence is part of the subgroup of Alcohol Use Disorders.

Degree of Impairment

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| Moderate           | Special Needs                               | Warning: Medications and natural substances should be used with a doctor’s approval.
| Moderate to Severe | Change of Location                          |                    |
| Severe             | Time off                                    |                    |

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Alcohol Abuse
Alcohol Intoxication
Alcohol Withdrawal
Generalized Anxiety Disorder
Delirium
Persisting Amnestic Disorder
Persisting Dementia
Mood Disorder
Psychotic Disorder
Sexual Dysfunction
Sleep Disorder

**Internet Resources**
http://www.mentalhealth.com/dis/p20-sb01.html
http://www.netdoctor.co.uk/health_advice/facts/alcoholism.htm
http://alcoholism.about.com/cs/effect/a/aa000510a.htm
ALCOHOL INTOXICATION

**Code Number:** 303.00  
**Category:** Substance-Related

**Behavioral Presentation**
- Recent intake of alcohol causing maladaptive behavior and psychological effects including overt sexual and physical aggression, mood swings, impaired judgment, social, and work functioning.
- *One or more of the following:* 1) slurred speech; 2) poor coordination; 3) unstable walking; 4) involuntary rhythmic eye movement; 5) impaired attention or memory; 6) stupor or memory loss.

**Specifiers, Codes and Comments**
- *Alcohol Intoxication* is part of the subgroup of Alcohol-Induced Disorders.
- From Latin – *intoxicare*, to poison, + *toxicum*, poison + *-ation*, indicating a process or condition.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Alcohol Abuse
- Alcohol Dependence
- Alcohol Withdrawal
- Generalized Anxiety Disorder
- Delirium
- Mood Disorder
- Persisting Amnestic Disorder
- Persisting Dementia
- Psychotic Disorder
- Sexual Dysfunction
- Sleep Disorder

**Internet Resources**
- [http://www.postgradmed.com/issues/2002/12_02/yost1.htm](http://www.postgradmed.com/issues/2002/12_02/yost1.htm)
- [http://www.mtholyoke.edu/offices/health/info/aod/intox.shtml](http://www.mtholyoke.edu/offices/health/info/aod/intox.shtml)
ALCOHOL WITHDRAWAL

Code Number: 291.8

Category: Substance-Related

Behavioral Presentation

- Stops alcohol intake suddenly after long term use.
- *Two or more of the following* within two hours to two days: 1) sweating; 2) rapid heartbeat; 3) hand tremors; 4) sleeplessness; 5) nausea or vomiting; 6) short term hallucinations or illusions; 7) heightened psychomotor activity; 8) anxiety; 9) grand mal seizures.

Specifiers, Codes and Comments

*With Perceptual Disturbances* – auditory, visual illusions, tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).

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Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Alcohol Abuse
Alcohol Dependence
Alcohol Intoxication
Delirium
Generalized Anxiety Disorder
Mood Disorder
Persisting Amnestic Disorder
Persisting Dementia
Psychotic Disorder
Sexual Dysfunction
Sleep Disorder

Internet Resources

http://alcoholism.about.com/cs/withdrawal/a/aa00125a.htm
http://www.drkoop.com/ency/article/000764.htm
http://www.ecureme.com/emyhealth/data/Alcohol_Withdrawal_Seizures.asp
AMNESTIC DUE TO GENERAL MEDICAL CONDITION

**Code Number:** 294.0

**Category:** Delirium, Dementia, Amnestic and Other Cognitive Presentation

### Behavioral Presentation

- Inability to learn new information or remember previously learned information.

### Specifiers, Codes and Comments

- **Transient** – no more than a month.
- **Chronic** – one month or more.

Note the General Medical Condition on Axis III

Note the exact name of the cause of the disorder.

Transient global amnesia consists of dense, transitory inability to learn new information. Additionally, the individual is unable to recall recent events just before and in the middle of a cerebrovascular problem.

- From Greek – *amnestos*, forgetting; *a-*, not + *mnasthai*, to remember.

### Degree of Impairment

- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

### Suggested Course of Action

- ☒ Medical Attention
- ☒ Therapy/Counseling
- ☒ Support Group
- ☒ Special Needs
- ☒ Change of Location
- ☒ Time off

### Psychopharmacology

- **Medications**
- **Natural Substance**
- ☒ None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

### Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Age-Related Cognitive Decline
Delirium
Dementia
Factitious Disorder
Malingering
Substance-Induced Persisting Amnestic Disorder
Substance-Intoxication Disorder
Substance-Withdrawal Disorder

### Internet Resources

http://www.behavenet.com/capsules/disorders/amnesticgmc.htm
http://www.psychiatry.ufl.edu/addiction/undergraded/course%20material/1.20.pdf
http://www.appi.org/book.cfm?id=2065
http://www.blackwellpublishing.com/content/BPL_Images/Content_store/Sample_chapter/1405103345%5Cmurphy.pdf
AMPHETAMINE ABUSE

Code Number: 305.70  
Category: Substance-Related

Behavioral Presentation

Over one twelve-month period, amphetamine intake causes clinical distress and impairment. 

One or more of the following within a twelve-month period: 1) affects work, social, and leisure functioning; 2) continues to use amphetamine in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of amphetamines; 5) amphetamine abuse leads to legal problems; 6) continues use despite knowing the effects on work, social, and personal problems.

Specifiers, Codes and Comments

Amphetamine Abuse is part of the subgroup of Amphetamine Use Disorders. 
Amphetamine-like substances: Dextroamphetamine, Methamphetamine, Methylnedioxymethylamphetamine (Ecstasy), and others.

Degree of Impairment  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
  None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Amphetamine Abuse
Amphetamine Intoxication
Amphetamine Withdrawal
Generalized Anxiety Disorder
Delirium
Mood Disorder
Persisting Amnestic Disorder
Persisting Dementia
Psychotic Disorder
Sexual Dysfunction
Sleep Disorder

Internet Resources

http://www.ecureme.com/emyhealth/data/Amphetamine_Abuse.asp

AMPHETAMINE DEPENDENCE
Behavioral Presentation

Over one twelve-month period amphetamine intake causes clinical distress and impairment.

*Three or more of the following* within a twelve-month period: 1) more amphetamine is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using, and recovering from the effects of amphetamine; 7) affects work, social, and leisure functioning; 8) continues to use amphetamine in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

*With Physiological Dependence* – evidence of tolerance or withdrawal.

*Without Physiological Dependence* – no evidence of tolerance or withdrawal.

*Early Full Remission* – for a period of one to twelve months does not meet criteria for Abuse or Dependence.

*Early Partial Remission* – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.

*Sustained Full Remission* – for twelve months or longer does not meet criteria for Abuse or Dependence.

*Sustained Partial Remission* – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.

*On Agonist Therapy* – on prescribed agonist medication.

*In a Controlled Environment* – is in a controlled environment: hospital or inpatient clinic.

Amphetamine Dependence is part of the subgroup of Amphetamine Use Disorders.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- **Moderate to Severe**
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
  - None Suggested

**Warning**: medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Amphetamine Abuse
- Amphetamine Intoxication
- Amphetamine Withdrawal
- Generalized Anxiety Disorder
- Delirium
- Mood Disorder
- Psychotic Disorder
- Sexual Dysfunction
Sleep Disorder

Internet Resources
http://www.med.umich.edu/1libr/aha/aha_amphedep_bha.htm
http://www.cochrane.org/cochrane/revabstr/AB003022.htm
http://www.drugwarfacts.org/methamph.htm
http://www.fairview.org/healthlibrary/content/aha_amphedep_bha.htm
AMPHETAMINE INTOXICATION

Code Number: 303.00  Category: Substance-Related

Behavioral Presentation
- Recent intake of Amphetamine causes maladaptive behavior and psychological effects including: changes in sociability, hyper vigilance, anger, anxiety or tension, impaired work or social functioning, blunted affect, stereotyped behaviors, interpersonal sensitivity, impaired judgment.
- Two or more of the following shortly after use: 1) slowed or rapid heart rate; 2) dilated pupils; 3) chills and sweating; 4) raised or lowered blood pressure; 5) nausea or vomiting; 6) weight loss; 7) heightenened or lowered psychomotor activity; 8) muscle weakness, shallower slowed breathing, chest pain or heart arrhythmia; 9) coma confusion, involuntary muscular activity, disordered muscle tone, or seizures.

Specifiers, Codes and Comments
- With Perceptual Disturbances – auditory, visual illusions; tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).
- Amphetamine Intoxication is part of the subgroup of Amphetamine-Induced Disorders.
- Amphetamine-like substances: Dextroamphetamine, Methamphetamine, Methylphenidate Methylnedioxymethylamphetamine (Ecstasy), and others.
- From Latin – intoxicare, to poison, + toxicum, poison + -ation, indicating a process or condition.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Amphetamine Abuse
Amphetamine Dependence
Amphetamine Withdrawal
Generalized Anxiety Disorder
Delirium
Mood Disorder
Psychotic Disorder
Sexual Dysfunction
Sleep Disorder

Internet Resources
http://www.emedicine.com/med/topic3114.htm
http://www.erowid.org/chemicals/amphetamines/amphetamines_effects.shtml
http://www.wrongdiagnosis.com/a/amphetamines/intro.htm
&dopt=Abstract
AMPHEMATINE WITHDRAWAL

**Code Number:** 292.0  
**Category:** Substance-Related

**Behavioral Presentation**
- Stops amphetamine intake suddenly after long term use.
- *Two or more of the following* within two hours to two days: 1) fatigue; 2) unpleasant, vivid dreams; 3) excessive sleepiness or sleeplessness; 4) increased appetite; 5) heightened or slowed psychomotor.

**Specifiers, Codes and Comments**
- Amphetamine-like substances: Dextroamphetamine, Methamphetamine, Methylenedioxyamphetamine (Ecstasy), and others.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Mediations
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Amphetamine Abuse
- Amphetamine Dependence
- Amphetamine Intoxication
- Generalized Anxiety Disorder
- Delirium
- Mood Disorder
- Psychotic Disorder
- Sexual Dysfunction
- Sleep Disorder

**Internet Resources**
- http://www.cochrane.org/cochrane/revabstr/AB003021.htm
ANOREXIA NERVOSA

Code Number: 307.1
Category: Eating

Behavioral Presentation

- Underweight as a result of over-dieting.
- May purge throughout the day, use laxatives, enemas, refuse food, over-exercise.
- Obsessed with being thin.
- Denies weight loss.

Specifiers, Codes and Comments

- Binge-Eating/Purging Type
- Restricting Type
- The diagnosis should not be made as result of a hunger strike.
- Studies suggest that approximately 0.5% of females and 0.05% of males may suffer from Anorexia Nervosa.
- From Greek – an, not or without + orexis, appetite; Latin – nervus, a nerve.

Degree of Impairment  Suggested Course of Action  Psychopharmacology

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Agoraphobia
Body Dysmorphic Disorder
Bulimia Nervosa
Major Depressive Episode
Obsessive-Compulsive Disorder
Panic Disorder
Social Phobia
Schizoid Personality
Somatization Disorder

Internet Resources
http://familydoctor.org/063.xml
http://www.4woman.gov/faq/easyread/anorexia-etr.htm
http://www.priory-hospital.co.uk/htm/anorex.htm
http://www.netdoctor.co.uk/diseases/facts/anorexianervosa.htm
ANTISOCIAL PERSONALITY

Code Number: 301.7
Category: Personality

Behavioral Presentation

★ Three or more of the following prior to age fifteen: 1) bullying and threatening; 2) starts fights; 3) uses weapons; 4) physical cruelty to people; 5) physical cruelty to animals; 6) theft with confrontation; 6) forced sex; 7) sets fires to cause damage; 8) destroyed property of others; 9) broke into a building, house, or car of others; 10) lies and breaks promises to avoid obligations; 11) steals valuables; 12) prior to age 13 stays out at night without parent’s permission; 13) twice or more has run away from home; 14) before age 13 has frequent truancies.

★ Three or more of the following prior to age fifteen: 1) commits acts that could lead to arrest; 2) lies, uses aliases, or cons for gain; 3) impulsive; 4) physically irritable or aggressive; 5) mean with no remorse.

★ Conduct Disorder if before the age of 15.

Specifiers, Codes, and Comments

❖ Antisocial Personality problems begin in early adult life around 18 or older.
❖ Personality Disorders are grouped in clusters. Antisocial Personality is part of Cluster “B” disorders.
❖ Overall, they disregard and violate others; will not conform to social norms. They are con artists, liars, murderers, violent, prostitutes, frauds, etc.
❖ Studies suggest that approximately 1% of females and 3% of males in the general population and 3% to 30% in clinical setting may suffer from Antisocial Personality Disorder.
❖ Antisocial Personality Disorders is also referred to as Sociopathy or Dissocial Personality Disorder.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Borderline Personality
Histrionic Personality
Manic Episode
Narcissistic Personality
Paranoid Personality
Schizoid Personality

Internet Resources
ASPERGER’S

**Code Number:** 299.80  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**

- **Two or more of the following:** 1) deficient social interaction via nonverbal behaviors, i.e.: 1) eye contact, facial expression, body posture, gestures; 2) inappropriate peer relationships; 3) absence of sharing achievements, interests or pleasure; 4) absence of social or emotional reciprocity.
- **One or more of the following:** 1) intense preoccupation with stereotyped and restricted interests, i.e., spinning things; 2) routines or rituals with no apparent function;
- 3) repetitive, stereotyped motor mannerisms, i.e., hand flapping; 4) absorbed with parts of objects.
- Causes clinical impairment in social, occupational or personal functioning; no language impairment delay. With the exception of social interaction there are no developing cognitive, age-appropriate self-help skills, adaptive behavior, or normal curiosity about the environment.

**Specifiers, Codes and Comments**

- Asperger’s is much less in its intensity than Autism.
- Asperger’s is part of a subgroup of Pervasive Developmental Disorders.
- Mental retardation, environmental deprivation, speech-motor or sensory deficit may worsen the individual’s problem.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

- Autistic
- Childhood Disintegrative Disorder
- General Anxiety Disorder
- Expressive Language Disorder
- Mixed Receptive-Expressive Language Disorder
- Obsessive-Compulsive Disorder
Personality Disorder
Rett’s
Schizoid Personality
Selective Mutism
Social Phobia

Internet Resources
http://www.aspergers.com/
http://users.wpi.edu/~trek/aspergers.html
http://www.udel.edu/bkirby/asperger/
http://www.mftsource.com/Treatment.asperger's.htm
ATTENTION-DEFICIT/HYPERACTIVITY

Code Number: 314.xx Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

INATTENTION – *six or more of the following* for six months or more: 1) does not pay attention to details or makes careless errors; 2) trouble keeping attention to tasks and play; 3) does not follow through on instructions or complete chores, schoolwork, jobs, etc.; 4) trouble organizing activities and tasks; 5) avoids tasks requiring sustained mental effort; 6) loses materials needed for activities; 7) easily distracted by external stimuli; 8) forgetful.

HYPERACTIVITY-IMPULSIVITY – *six or more of the following* for six months or more: 1) squirms and fidgets; 2) unexpectedly leaves seat; 3) unexpectedly runs or climbs; 4) trouble playing quietly or practicing in leisure activity; 5) driven and on-the-go; 6) talks excessively; 7) answers questions before they have been asked completely; 8) trouble awaiting turn; 9) interrupts and intrudes on others.

Some symptoms began before age seven.

Specifiers, Codes and Comments

- Attention-Deficit/Hyperactivity, Combined Type (Code – 314.01).
- Attention-Deficit/Hyperactivity, Predominantly Inattentive Type (Code – 314.00).
- Attention-Deficit/Hyperactivity, Predominantly Hyperactive, Impulsive Type (Code – 314.00).
- In Partial Remission – adolescents and adults who have symptoms that do not meet the full criteria for Attention-Deficit/Hyperactivity Disorder.

Attention-Deficit/Hyperactivity Disorder is part of a subgroup of Attention-Deficit/Hyperactivity Behavior Disorders.

Studies suggest that approximately 3% to 7% of school-age children may suffer from Attention-Deficit/Hyperactivity Disorder.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Generalized Anxiety Disorder
Dissociative Disorder
Mental Retardation
Mood Disorder
Pervasive Developmental Disorder
Personality Disorder
Psychotic Disorder
Stereotyped Movement Disorder

Internet Resources
http://www.chadd.org/
http://www.mentalhealth.com/dis/p20-ch01.html
http://www.cdpage.com/adhd.htm
http://www.mhsanctuary.com/add/
AUTISTIC

Code Number: 299.00 Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Two or more of the following: 1) deficient social interaction via nonverbal behaviors, i.e., eye contact, facial expression, body posture, and gestures; 2) inappropriate peer relationships; 3) absence of sharing achievements, interests or pleasure; 4) absence of social or emotional reciprocity.

One or more of the following: 1) delayed or absent development of spoken language without compensation through gestures; 2) unable to begin or sustain conversation (of those who can speak); 3) repetitive, stereotyped or idiosyncratic language; 4) social imitative play or spontaneous, make-believe play is absent.

One or more of the following: 1) intense preoccupation with stereotyped and restricted interests, i.e., spinning things; 2) routines or rituals with no apparent function;

3) repetitive, stereotyped motor mannerisms, i.e., hand flapping; 4) absorbed with parts of objects.

Lack of One or more of the following before age of three: 1) social interaction; 2) language used in social communication; 3) play that is imaginative and symbolic.

Specifiers, Codes and Comments

Autistic Disorder is part of a subgroup of Pervasive Developmental Disorders.

Mental retardation, environmental deprivation, speech-motor or sensory deficit may worsen the individual’s problem.

Studies suggest that approximately 2 to 20 cases per 10,000 individuals may suffer from Autistic Disorder.

Autism may also be referred to as Childhood Autism, Infantile Autism, and Kanner's Syndrome.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Asperger’s
Attention-Deficit/Hyperactivity Disorder
Childhood Disintegrative Disorder
Expressive Language Disorder
Mental Retardation
Mixed Receptive-Expressive Language Disorder
Rett’s
Schizoid Personality
Selective Mutism
Stereotypic Movement Disorder

Internet Resources
http://www.nas.org.uk/
http://www.autism.org/contents.html
AVOIDANT PERSONALITY

Code Number: 301.82  
Category: Personality

Behavioral Presentation

Four or more of the following: 1) avoids interpersonal occupational contact due to fear, criticism, disapproval, or rejection; 2) must know they will be liked before becoming involved with others; 3) fear of ridicule or shame holds them back from being in intimate relationships; 4) fear of being criticized or rejected in social situations; 5) feelings of inadequacy cause inhibitions in new relationships; 6) believes they are inferior, unappealing, or inept; 7) avoids new activities or personal risk due to fear of embarrassment.

Specifiers, Codes and Comments

- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Avoidant Personality is part of Cluster “C” disorders.
- Studies suggest that approximately 0.5% to 1.0% of the general population and 10.0% of psychiatric outpatients may suffer from Avoidant Personality.
- Avoidant Personality Disorder may also be referred to as Anxious Personality Disorder.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Dependent Personality
Panic Disorder with Agoraphobia
Paranoid Personality
Personality Disorder
Social Phobia, Generalized Type
Schizotypal Personality
Schizoid

Internet Resources
http://open-mind.org/SP/Articles/1c.htm
http://groups.msn.com/AvoidantPersonalityGroup/_whatsnew.msnw
http://www.behavenet.com/capsules/disorders/avoidantpd.htm
http://www.toad.net/~arcturus/dd/avoid.htm
BEREAVEMENT

Code Number: V62.82

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
As the result of the death of a loved one or friend, the individual grieves for a period that does not qualify him or her for a diagnosis of a Mood Disorder.

Specifiers, Codes and Comments
Grieving can often appear to be a depressive disorder, including feelings of guilt, death wishes, slowed psychomotor activity, feeling worthless, and/or hallucinations.
Although some would debate the following, grieving may include the loss of a job, housing, friendships, and relationship with a partner, etc.

Degree of Impairment

<table>
<thead>
<tr>
<th></th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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</thead>
<tbody>
<tr>
<td>Very Mild</td>
<td>Medical Attention</td>
<td>Medications</td>
</tr>
<tr>
<td>Mild</td>
<td>Therapy/Counseling</td>
<td>Natural Substance</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
<td>None Suggested</td>
</tr>
<tr>
<td>Moderate</td>
<td>Special Needs</td>
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</tr>
<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
<td>Warning: Medications and natural substances should be used with a doctor’s approval.</td>
</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
<td></td>
</tr>
</tbody>
</table>

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Mood Disorder

Internet Resources
http://www.ncpamd.com/bereavement.htm
http://www.growthhouse.org/death.html
http://www.aplb.org/
http://hcd2.bupa.co.uk/fact_sheets/mosby_factsheets/Bereavement.html
BIPOLAR I

Code Number: None

Category: Mood

Behavioral Presentation
- One or more Manic Episodes or Mixed Episodes.
- Many will have one or more Major Depressive Episodes.

Specifiers, Codes and Comments
Group A: Only if the criteria for Manic Episodes, Mixed Episodes, or Major Depressive Episodes are met.
- Mild – barely meet the criteria (Code – .x1).
- Moderate – between mild and severe (Code – .x2).
- Severe Without Psychotic Features – exceed minimum criteria (Code – .x3).
- Severe With Psychotic Features – delusions and hallucinations (Code – .x4).

Group B: Only if the criteria are not for Manic Episodes, Mixed Episodes, or Major Depressive Episodes are met.
- In Partial Remission – have fewer than five symptoms or no symptoms for two months or less (Code – .x5).
- In Full Remission – no symptoms for two months or more (Code – .x6).
- With Catatonic Features.
- With Postpartum Onset – symptoms come about after the birth of a child.

Group C: Only if the criteria Major Depressive Episode is met.
- Chronic – lasting two or more years.
- With Melancholic Features – loss of most or all interest in pleasurable activities.
- With Atypical Features – mood gets better in the light of upcoming positive events.

Group D: Use to note the pattern of the Episodes.
- With Interepisode Recovery – periods of few symptoms.
- Without Interepisode Recovery – no periods of being symptom-free.
- With Seasonal Pattern – symptoms relate to the time of year.
- With Rapid Cycling – changes in moods are frequent and fast (Code – .x6).

Internet Resources
http://www.nimh.nih.gov/publicat/bipolar.cfm
http://www.bipolar.com/
http://www.mhsources.com/bipolar/?_requestid=143803
http://www.bipolarbrain.com/
BIPOLAR I, MOST RECENT EPISODE DEPRESSED

Code Number: 296.5x

Category: Mood

Behavioral Presentation

- Most recent episode is a Major Depressive Episode being depressed; problems with eating, sleeping; feelings of guilt; loss of energy; trouble concentrating; and/or suicidal thoughts.
- Previously experienced one or more Manic Episode or Mixed Episodes.

Specifiers, Codes and Comments

- See Major Depressive Episode for coding “x” types.
- If full criteria a met for Major Depressive Episode, see Groups A, B, C, and D for Bipolar I Disorder, but exclude specifiers In partial Remission and In Full Remission.
- If full criteria are not met for Major Depressive Episode, see Groups A, B, C, and D for Bipolar I Disorder, but exclude Specifiers; Mild, Moderate and Severe With Psychotic Features and Severe with Psychotic features.
- Bipolar I Disorder, Single Manic Episode is part of a subgroup of Bipolar Disorders.
- Studies suggest that the lifetime prevalence is approximately 0.4% to 1.6% for Bipolar Disorders.
- From Latin – bis twice + polaris, of or relating to a pole, polus, a pole.

Degree of Impairment

<table>
<thead>
<tr>
<th>Very Mild</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Medical Attention</td>
<td>Medications</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>Therapy/Counseling</td>
<td>Natural Substance</td>
</tr>
<tr>
<td>Moderate</td>
<td>Support Group</td>
<td>None Suggested</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
<td>Warning: Medications and</td>
</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
<td>natural substances should be</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe</th>
</tr>
</thead>
</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Bipolar II Disorder
Cyclothymic Disorder
Delusional Disorder
Dysthmic Disorder
Major Depressive Episode
Psychotic Disorder
Schizoffective
Schizoid Personality

Internet Resources
http://www.behavenet.com/capsules/disorders/bip1dismr.htm
http://www.mental-health-today.com/bp/bi1.htm
http://www.biologicalunhappiness.com/Bipolar1.htm
http://www.twilightbridge.com/psychiatryproper/diagnosticcriteria/DSMIV/dsmbipolar_i_disord
BIPOLAR I, MOST RECENT EPISODE HYPOMANIC

Code Number: 296.40

Category: Mood

Behavioral Presentation

- Less severe than a Manic Episode (Pg. 206) of being elated; may be irritable, grandiose, talkative, hyperactive, distractable; need for more or less sleep.
- Previously had one or more of the following: Manic (Pg. 179) or Mixed (Pg. 183) Episode.

Specifiers, Codes and Comments

- See Hypomanic Episode (Pg. 193) for coding “x” types.
- Use group D (Pg. 98) for Bipolar I Disorder.
- Bipolar I Disorder, Most Recent Episode Hypomanic Episode is part of a subgroup of Bipolar Disorders.
- Studies suggest that the lifetime prevalence is approximately 0.4% to 1.6% of those who may suffer from Bipolar Disorders.
- From Latin – bis twice + polaris, of or relating to a pole, polus, a pole.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
  - None Suggested
  - Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Bipolar II Disorder
Cyclothymic Disorder
Delusional Disorder
Dysthmic Disorder
Major Depressive Episode
Psychotic Disorder
Schizoaffective Disorder
Schizoid Personality

Internet Resources

http://www.behavenet.com/capsules/disorders/bip1reh.htm
http://www.earlychildhoodbehavioralhealth.com/Disorders/bipolarI.htm
http://www.mental-health-today.com/bp/bi1-2.htm
http://www.biologicalunhappiness.com/Bipolar1.htm
BIPOLAR I, MOST RECENT EPISODE MANIC

Code Number: 296.4x  
Category: Mood

Behavioral Presentation

- Most recent episode is a Manic Episode being elated; may be irritable, grandiose, talkative, hyperactive, distractible; need for more or less sleep.
- At least one previous Major Depressive Episode, Manic Episode, or Mixed Episode of being depressed, problems with eating, sleeping; feelings of guilt; loss of energy; trouble concentrating; suicidal thoughts or at least one Mixed Episode (Pg. 183).

Specifiers, Codes and Comments

- See Manic Episode for coding “x” types.
- If full criteria are met for Manic Episode, see Groups A, B, C, and D (Pg. 98) for Bipolar I Disorder, but exclude specifies; In partial Remission and In Full Remission.
- If full criteria are not met for Manic Episode, see Groups B and D (Pg. 179) for Bipolar I Disorder, but exclude specifies; Mild, Moderate, Severe With Psychotic Features and Severe with Psychotic features.
- Bipolar I Disorder, Most Recent Episode Manic is part of a subgroup of Bipolar Disorders.
- Studies suggest that the life time prevalence is approximately 0.4% to 1.6% for those who may suffer from Bipolar Disorders.
- From Latin – bis twice + polaris, of or relating to a pole, polus, a pole.

Degree of Impairment  
Very Mild  
Mild  
Mild to Moderate  
Moderate  
Moderate to Severe  
Severe

Suggested Course of Action  
Medical Attention  
Therapy/Counseling  
Support Group  
Special Needs  
Change of Location  
Time off

Psychopharmacology  
Medications  
Natural Substance  
None Suggested  
Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Bipolar II Disorder  
Cyclothymic Disorder  
Delusional Disorder  
Dysthymic Disorder  
Major Depressive Episode  
Psychotic Disorder  
Schizoaffective Disorder  
Schizoid Personality

Internet Resources

http://www.earlychildhoodbehavioralhealth.com/Disorders/bipolarI.htm  
http://www.mental-health-today.com/bp/bi1.htm
http://www.geocities.com/SouthBeach/Shores/6052/bp1.html
http://www.healthyplace.com/communities/bipolar/site/bipolar_disorder.htm
BIPOLAR I, MOST RECENT EPISODE MIXED

Code Number: 296.6x
Category: Mood

Behavioral Presentation

Most recent episode is Mixed with Manic Episode being elated; may be irritable, grandiose, talkative, hyperactive, distractible; need for more or less sleep mixed with Major Depressive Episode (Pg. 200) being depressed; problems with eating, sleeping, feelings of guilt; loss of energy; trouble concentrating; and/or suicidal thoughts.

At least one Major Depressive Episode, Manic Episode, or Mixed Episode.

Specifiers, Codes and Comments

See Manic Episode for coding “x” types.
See Major Depressive Episode for coding “x” types.
If full criteria are met for Mixed Episode, see Groups A, B, C, and D for Bipolar I Disorder, but exclude specifiers In partial Remission and In Full Remission.
If full criteria are not met for Mixed Episode see Groups B and D for Bipolar I Disorder, but exclude specifies Mild, Moderate, Severe With Psychotic Features and Severe with Psychotic features.
Bipolar I Disorder, Most Recent Episode Mixed, is part of a subgroup of Bipolar Disorders.
Studies suggest that the lifetime prevalence is approximately 0.4% to 1.6% for Bipolar Disorders.
From Latin – bis twice + polaris, of or relating to a pole, polus, a pole.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Bipolar II Disorder
Cyclothymic Disorder
Delusional Disorder
Dysthymic Disorder
Major Depressive Episode
Psychotic Disorder
Schizoaffective Disorder
Schizoid Personality

Internet Resources
http://www.behavenet.com/capsules/disorders/bip1mrem.htm
http://www.biologicalunhappiness.com/Bipolar1.htm
http://www.geocities.com/morrison94/mood.htm
http://www.psychnet-uk.com/dsm_iv/bipolar_disorder.htm
BIPOLAR I, SINGLE MANIC EPISODE

**Code Number:** 296.0x

**Category:** Mood

### Behavioral Presentation
- One Manic Episode of being elated; may be irritable, grandiose, talkative, hyperactive, distractable; need for more or less sleep.
- No past Major Depressive Episodes.

### Specifiers, Codes and Comments
- See Manic Episode for coding “x” types.
- If the criteria for Mixed Episode is met use coding “x” types.
- If full criteria are met for Manic Episode, Mixed Episode or Major Depressive Episode, see Group A for Bipolar I Disorder.
- If full criteria are not met for Manic Episode, Mixed Episodes, or Major Depressive Episodes see Group B for Bipolar I Disorder.
- Bipolar I Disorder, Single Manic Episode, is part of a subgroup of Bipolar Disorders.
- Studies suggest that the lifetime prevalence is approximately 0.4% to 1.6% for those who may suffer from Bipolar Disorders.
- From Latin – *bis* twice + *polaris*, of or relating to a pole, *polus*, a pole.

### Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

### Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

### Psychopharmacology
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

### Alternate Diagnostic Presentation

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

Bipolar II Disorder
Cyclothymic Disorder
Delusional Disorder
Dysthymic Disorder
Major Depressive Episode
Psychotic Disorder
Schizoaffective Disorder
Schizoid Personality

### Internet Resources
- http://groups.msn.com/PsychHelp/bipolardisorder.msnw
- http://psychceu.com/paintedponiesintro.html
- http://www.psych.org/psych_pract/treatg/pg/bipolar_revisebook_1.cfm
BIPOLAR II

Code Number: 296.89

Category: Mood

Behavioral Presentation

● One or more of the following: 1) Major Depressive Episode of being depressed; 2) problems with eating, sleeping; 3) feelings of guilt; 4) loss of energy; 5) trouble concentrating; 6) suicidal thoughts; 7) problems with sleep.

● At least one Hypomanic Episode of being elated; may be irritable, grandiose, talkative, hyperactive, distractible to a lesser degree than Manic.

● No Manic Episodes or Mixed Episodes.

Specifiers, Codes and Comments

- Hypomanic – specify if the current or most recent episode is a Hypomanic Episode.
- Depressed – specify if the current or most recent episode is a Major Depressive Episode.
- See Manic Episode for coding “x” types.

Bipolar II Disorder is also known as Bipolar II Recurrent Major Depressive with Hypomanic Episodes.

If the criteria for Bipolar II is met use coding “x” types.

If full criteria are met for Major Depressive Episode see Groups A, B, C, and D for Disorder, but do not include: In Partial Remission or In Full Remission.

If full criteria are not met for Hypomanic Episodes or Major Depressive Episodes, see Groups B, C and D for Bipolar I Disorder.

Bipolar I Disorder, Single Manic Episode, is part of a subgroup of Bipolar Disorders.

Studies suggest that the lifetime prevalence is approximately 0.5% for those who may suffer from Bipolar II Disorders.

From Latin – bis twice + polaris, of or relating to a pole, polus, a pole.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications.
- Natural Substance.

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Bipolar I Disorder
Cyclothymic Disorder
Delusional Disorder
Dysthymic Disorder
Major Depressive Episode
Psychotic Disorder
Schizoaffective Disorder
Schizoid Personality

Internet Resources
http://www.a-silver-lining.org/BPNDepth/dsmiv.html
http://psychological.com/mood_disorders.htm
http://www.fpnotebook.com/PSY23.htm
BODY DYSMORPHIC

**Code Number:** 300.7

**Category:** Somatoform

### Behavioral Presentation
- Preoccupation with a body part they believe is defective: nose, eyes, ears, stomach, legs, etc.
- Dwells and is fixated on the problem.
- Individual believes the perceived anatomical problem(s) is real.

### Specifiers, Codes and Comments
- Body Dysmorphic Disorder is also referred to as Dysmorphophobia.
- From Greek – *dys*, bad or abnormal + *morphe*, form.

### Degree of Impairment
- Very Mild
- **Mild**
  - Mild to Moderate
  - Moderate
  - Moderate to Severe
- **Severe**

### Suggested Course of Action

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<tr>
<th>Degree of Impairment</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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<td>Therapy/Counseling</td>
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<td>Support Group</td>
<td>None Suggested</td>
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<td>Special Needs</td>
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<td>Change of Location</td>
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<td>Time off</td>
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</table>

### Degree of Impairment

### Psychopharmacology

- **Warning:** Medications and natural substances should be used with a doctor’s approval.

### Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

- Anorexia Nervosa
- Avoidant Personality
- Delusional Disorder
- Gender Identity Disorder
- Hypochondriasis Disorder
- Obsessive-Compulsive Disorder
- Mood Disorder
- Schizoid Personality
- Social Phobia
- Transvestic Fetishism
- Trichotillomania

### Internet Resources
- [http://www.biopsychiatry.com/bdd.html](http://www.biopsychiatry.com/bdd.html)
- [http://www.healthyplace.com/Communities/Eating_Disorders/peacelovehope/bdd.html](http://www.healthyplace.com/Communities/Eating_Disorders/peacelovehope/bdd.html)
BORDERLINE INTELLECTUAL FUNCTIONING

Code Number: V62.89
Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Individual’s Intelligence Quotient (IQ) and level of functioning is low, but does not qualify for a diagnosis of Mild Mental Retardation.

Specifiers, Codes and Comments
The individual’s IQ level of functioning may fall between 71 to 84.

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | Therapeutic/Counseling | Medications
Mild | Support Group | Natural Substance
Mild to Moderate | Special Needs | None Suggested
Moderate | Change of Location | Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe | Time off | Special Needs
Severe | | None Suggested

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Cognitive Disorder
Mild Mental Retardation
Psychotic Disorder

Internet Resources
- http://www.findarticles.com/p/articles/mi_m2248/is_130_33/ai_65306465
- http://www.theglenholmeschool.org/special%20topics/borderline.htm
BORDERLINE PERSONALITY

Code Number: 301.83 Category: Personality

Behavioral Presentation

Five or more of the following: 1) frantically avoids abandonment; 2) moves from idealizing to devaluing relationships; 3) unstable self-image or sense of self; 4) two of: binge eating, reckless driving, sex, spending, or substance use; 5) suicidal thoughts, self-mutilation and/or threatening; 6) intense anxiety, depression and/or irritability lasting hours to a few days; 7) feelings of emptiness; 8) frequent temper tantrums, repeated physical fights and/or constantly feeling angry.

Brief paranoid thoughts or dissociative symptoms.

Specifiers, Codes and Comments

- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Antisocial Personality is part of Cluster “B” Disorders.
- Studies suggest that approximately 2% of the general population, 10% of the outpatient mental health patients, and 20% of psychiatric inpatients may suffer from Borderline Personality Disorder.
- Borderline Personality Disorder may comprise approximately 30% to 60% of all Personality Disorders.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Change of Location
Warning: Medications and natural substances should be used with a doctor’s approval.

Special Needs
Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Antisocial Personality
Dependent Personality
Histrionic Personality
Mood Disorder
Narcissistic Personality
Paranoid Personality
Schizotypal Personality

Internet Resources

http://www.stanford.edu/~corelli/borderline.html
http://www.nimh.nih.gov/publicat/bpd.cfm
http://www.mentalhealth.com/dis/p20-pe05.html
http://www.suite101.com/welcome.cfm/borderline_personality
BREATHING-RELATED SLEEP

Code Number: 780.59  
Category: Sleep

Behavioral Presentation
- Sleep disruption causes Insomnia, inability to sleep, or Hypersomnia.
- Inability to sleep as a result of breathing problems related to Central Sleep Apnea or Obstructive Sleep Apnea or Central Alveolar Hypoventilation Syndrome.

Specifiers, Codes and Comments
- Breathing-Hypersomnia Sleep Disorder is part of a subgroup of Dyssomnias.
- Breathing-Related Sleep Disorder is sometimes referred to as Ondine’s Curse.
- Studies suggest that approximately 1% to 10% of the adult population may suffer from Breathing-Related Sleep Disorder with higher rates amongst the elderly.
- From Greek – dys, bad or abnormal + somnus, sleep.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Attention-Deficit/Hyperactivity Disorder
Circadian Rhythm Sleep Disorder
Primary Hypersomnia
Primary Insomnia
Major Depressive Episode
Narcolepsy
Nocturnal Panic Attack

Internet Resources
http://www.emedicine.com/med/topic3130.htm
http://www.chclibrary.org/micromed/00065510.html
http://www.healthsuperstore.com/articles/sleep/sleep_disorder.asp
BRIEF PSYCHOTIC

Code Number: 298.8

Category: Schizophrenia and Other Psychotic Disorders

Behavioral Presentation

- One or more of the following: 1) delusions; 2) hallucinations; 3) disorganized speech; 4) grossly disorganized or Catatonic behavior.
- One day to one month in duration with complete premorbid recovery.

Specifiers, Codes and Comments

- With Postpartum Onset – within four weeks of giving birth.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Delusional Disorder
Factitious Disorder With Predominantly Psychological Signs and Symptoms
Malingering
Mood Disorder with Psychotic Features
Personality Disorder
Schizoaffective Disorder

Internet Resources

http://www.emedicine.com/med/topic3479.htm
http://www.psychnet-uk.com/dsm_iv/brief_psychotic_episode.htm
http://www.wrongdiagnosis.com/b/brief_psychotic_disorder/intro.htm
BULIMIA NERVOSA

**Code Number:** 307.51  
**Category:** Eating

**Behavioral Presentation**
- Occurring twice per month over three consecutive months the individual’s binge-eating followed by purging through self-induced vomiting.
- Controls weight by fasting, over exercising, self-induced vomiting, over-use of laxatives, diuretics, or other drugs.
- Obsessed with being the proper weight.

**Specifiers, Codes and Comments**
- **Purging Type** – intentionally forces food out of the body.
- **Nonpurging Type** – has not regularly forced food out of the body.
- Binge episodes consists of eating more food than most others would eat in a single sitting.
- Studies suggest that approximately 1% to 3% of females and 0.1% to 0.3% of males may suffer from Bulimia Nervosa.
- From – *bulimia*; Latin – *nervus*, a nerve.

**Degree of Impairment**  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**  
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**  
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Anorexia
- Antisocial Personality
- Binge-Eating Disorder
- Body Dysmorphic Disorder
- Borderline Personality
- Depression, Personality

**Internet Resources**
- [http://www.priory-hospital.co.uk/htm/bulimi.htm](http://www.priory-hospital.co.uk/htm/bulimi.htm)
- [http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=7638](http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=7638)
CAFFEINE INTOXICATION

Code Number: 305.90
Category: Substance-Related

Behavioral Presentation

Recent intake of caffeine, two to three eight ounce cups of coffee, cola, or any substance containing caffeine.

Five or more of the following: 1) restlessness; 2) nervousness; 3) excitement; 4) sleeplessness; 5) red face; 6) increased urination; 7) gastrointestinal upset; 8) muscle twitching; 9) rambling speech; 10) periods of tirelessness; 11) speeded-up psychomotor activity; 12) rapid or irregular heartbeat.

Specifiers, Codes and Comments

Caffeine Intoxication is part of the subgroup of Caffeine-Induced Disorders.

From Latin – intoxicare, to poison, + toxicum, poison + -ation, indicating a process or condition.

Degree of Impairment

| Very Mild | Mild | Mild to Moderate | Moderate | Moderate to Severe | Severe |

Suggested Course of Action

| Medical Attention | Therapy/Counseling | Support Group | Special Needs | Change of Location | Time off |

Psychopharmacology

| Medications | Natural Substance |

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Sleep Disorder

Internet Resources
http://www.digitalnaturopath.com/cond/C569985.html
http://en.wikipedia.org/wiki/Caffeine
http://carolinareporter.sc.edu/archive%204-12-20/caffeine.html
http://groups.msn.com/FoodiesCorner/caffeineaddiction.msnw
**CANNABIS ABUSE**

**Code Number:** 305.20  
**Category:** Substance-Related

**Behavioral Presentation**

- Over one twelve-month period, Cannabis intake causes clinical distress and impairment.
- *One or more of the following:* 1) affects work, social and leisure functioning; 2) continues to use cannabis in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of cannabis; 5) cannabis abuse leads to legal problems; 6) continues use in spite knowing the effects on work, social and personal problems.

**Specifiers, Codes and Comments**

- Cannabis Abuse is part of the subgroup of Cannabis Use Disorders.
- Cannabis is more commonly known as marijuana, dope, ganja, grass, joint, pot, reefer, spliff, weed, Mary Jane, Wacky-Tabacky, and others.
- From Latin – *Cannabis*.

**Degree of Impairment**

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<th>Impairment</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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<tbody>
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<td>Very Mild</td>
<td>Medical Attention</td>
<td>❌ Medications</td>
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<tr>
<td>❌ Mild</td>
<td>Therapy/Counseling</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
<td>None Suggested</td>
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<td>Moderate</td>
<td>Special Needs</td>
<td>Warning: Medications and</td>
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<td>natural substances should be</td>
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<td>used with a doctor’s approval.</td>
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<td>Moderate to Severe</td>
<td>Change of Location</td>
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<tr>
<td>Severe</td>
<td>Time off</td>
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</tbody>
</table>

**Alternate Diagnostic Presentation**

- *Always rule out* General Medical Conditions
- *Always rule out* Substance Related Disorders

- Generalized Anxiety Disorder
- Cannabis Dependence
- Cannabis Intoxication
- Delirium
- Psychotic Disorders with Delusions
- Psychotic Disorders with Hallucinations

**Internet Resources**

- http://www.mikuriya.com/cantox.html
- http://www.who.int/substance_/abuse/facts/cannabis/en
CANNABIS DEPENDENCE

Code Number: 304.30 Category: Substance-Related

Behavioral Presentation

Over one twelve-month period Cannabis intake causes clinical distress and impairment.

Three or more of the following within a twelve-month period: 1) more Cannabis is needed for the same effect, or the same amount has less effect; 2) duration of use is greater over time; 3) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 4) tries to control use; 5) spends a lot of time looking for, using, and recovering from the effects of Cannabis; 6) effects work, social, and leisure functioning; 7) continues to use Cannabis in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

With Physiological Dependence – evidence of tolerance or withdrawal.

Without Physiological Dependence – no evidence of tolerance or withdrawal.

Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.

Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.

Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.

Sustained Partial Remission – for twelve months or longer does not meet criteria Dependence, but one or more of the criteria for Abuse and Dependence have been met.

On Agonist Therapy – on prescribed agonist medication.

In a Controlled Environment – is in a controlled environment–hospital or inpatient clinic.

Cannabis Dependence is part of the subgroup of Cannabis Use Disorders.

From Latin – Cannabis.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Cannabis Abuse
Cannabis Intoxication
Delirium
Psychotic Disorders with Delusions
Psychotic Disorders with Hallucinations

**Internet Resources**
http://www.mentalhealth.com/dis/p20-sb03.html
http://www.wrongdiagnosis.com/c/cannabis_dependence/intro.htm
http://www.psychologynet.org/cannabis.html
CANNABIS INTOXICATION

Code Number: 292.89

Category: Substance-Related

Behavioral Presentation
Recent intake of Cannabis causing maladaptive behavior and psychological effects including motor performance deficits, anxiety, euphoria, impaired judgment, social withdrawal, feeling that time has slowed, and lack of inhibition.

Two or more of the following within two hours of use: 1) red eyes; 2) increased appetite; 3) dry mouth; 4) rapid heart rate.

Specifiers, Codes and Comments

With Perceptual Disturbances – auditory, visual illusions, tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).

Cannabis is more commonly known as marijuana, dope, ganja, grass, joint, pot, reefer, spliff, weed, Mary Jane, Wacky-Tabacky.

From Latin – intoxicare, to poison, + toxicum, poison + -ation, indicating a process or condition.

From Latin – Cannabis.

Degree of Impairment

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<th>Degree of Impairment</th>
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<td>Severe</td>
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</tbody>
</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Cannabis Abuse
Cannabis Dependence
Delirium
Psychotic Disorders with Delusions
Psychotic Disorders with Hallucinations

Internet Resources
http://www.druglibrary.org/schaffer/hemp/medical/ch5.htm
http://www.behavenet.com/capsules/disorders/cannatoxication.htm
http://www.drgreene.org/body.cfm?id=49&action=Display&articlenum=952
CHILDHOOD DISINTEGRATIVE

Code Number: 299.10

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Two or more of the following before the age of ten lose of: 1) expressive or receptive language; 2) social skills or adaptive behavior; 3) bladder or bowel control; 3) play; 4) motor skills.

Two or more of the following: 1) social interaction characterized through nonverbal behaviors, peer relationships, or emotional reciprocity; 2) delayed or absent spoken language, inability to converse; 3) repetitive or stereotyped play, or absence of varied make-believe play.

Specifiers, Codes and Comments

Until the age of two, the child develops normally, i.e, both nonverbal and verbal communication, adaptive behavior, social relationships, and play.

Childhood Disintegrative Disorder is part of a subgroup of Pervasive Developmental Disorders.

Mental retardation, environmental deprivation, speech-motor or sensory deficit may worsen the individual’s problem.

Studies suggest that Childhood Disintegrative Disorder is rare, much less common than Autistic Disorder.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Asperger’s
Autistic Disorder
Dementia
Rett’s

Internet Resources

http://info.med.yale.edu/chldstdy/autism/cdd.html
http://www.psychnet-uk.com/dsm_iv/childhood_disintegrative_disorder.htm
http://www.wrongdiagnosis.com/c/childhood_disintegrative_disorder/intro.htm
**CHRONIC MOTOR OR VOCAL TIC**

**Code Number:** 307.22  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**
- One or more vocal or multiple motor tics that begin before age 18.
- For one or more years the individual tics each day, almost every day, or at intervals.
- Tics never stop longer than three months.

**Specifiers, Codes and Comments**
- Chronic Motor or Vocal Tic Disorder is part of a subgroup of Tic Disorders.
- A tic is a motor movement or vocalization that is non-rhythmic, rapid, repeated, stereotyped, or sudden.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Athetoid Movements
- Chorea
- Dystonic Movements
- Hemiballismic Movement
- Myoclonic Movements
- Pervasive Development Disorder
- Schizoid Personality
- Stereotypic Movement Disorder
- Transient Tic Disorder
- Tourette’s

**Internet Resources**
- [http://www.healthcentral.com/mhc/top/000745.cfm](http://www.healthcentral.com/mhc/top/000745.cfm)
- [http://www.drkoop.com/ency/article/000745.htm](http://www.drkoop.com/ency/article/000745.htm)
- [http://www.tsa-usa.org/research/definitionstable.html](http://www.tsa-usa.org/research/definitionstable.html)
CIRCADIAN RHYTHM SLEEP

**Code Number:** 307.45  
**Category:** Sleep

**Behavioral Presentation**
- Sleep problems related to the environment.
- Wake and sleep patterns are disrupted leading to Insomnia or Hypersomnia.

**Specifiers, Codes and Comments**
- *Jet Lag Type* – traveling across time zones causes sleep disturbance.
- *Shift Work Type* – due to night shift work or inconsistent work scheduling.
- *Delayed Sleep Phase Type* – trouble getting to sleep or waking up.
- *Unspecified Type* – does not fall into the three previously mentioned categories.

Circadian Rhythm Sleep Disorder is part of a subgroup of Dyssomnias.
Circadian Rhythm Sleep Disorder was formerly known as Sleep-Wake Schedule Disorder.
Studies suggest that approximately 0.1% to 4% of adults and 7% of adolescents may suffer from Circadian Rhythm Sleep Disorder.
Studies suggest that approximately 60% of night shift workers may suffer from Circadian Rhythm Sleep.
Dyssomnias from Greek – *dys*, bad or abnormal + *somnus*, sleep.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
  - None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Breathing-Related Sleep Disorder
Major Depressive Episode
Primary Hypersomnia
Primary Insomnia

**Internet Resources**
- http://www.psychnet-uk.com/dsm_iv/circadian_rhythm_sleep_disorder.htm
- http://www.bpchildresearch.org/research/current_study.html
- http://www.northwestern.edu/cseb/about.html
- http://www.apollolight.com/new_content/circadian%20rhythms_disorders/sleep/circadian_sleep_disorders.html
COCAINE ABUSE

Code Number: 305.60  
Category: Substance-Related

Behavioral Presentation

Over one twelve-month period cocaine intake causes clinical distress and impairment.

One or more of the following within a twelve-month period: 1) affects work, social, and leisure functioning; 2) continues to use cocaine in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of cocaine; 5) cocaine abuse leads to legal problems; 6) continues use in despite knowing the effects on work, social and personal problems

Specifiers, Codes and Comments

Cocaine Abuse is part of the subgroup of Cocaine Use Disorders.

Cocaine is also known as Blow, Crack, Snow, and White Lady.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
  - None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Cocaine Dependence
Cocaine Intoxication
Cocaine Intoxication
Delirium
Mood Disorder
Psychotic Disorders with Delusions
Psychotic Disorders with Hallucinations
Sexual Dysfunction
Sleep Disorder

Internet Resources
http://www.focusas.com/Cocaine.html
http://www.jr2.ox.ac.uk/bandolier/band1/b1-7.html
http://health.discovery.com/encycledias/566.html
COCAINE DEPENDENCE

Code Number: 304.20

Category: Substance-Related

Behavioral Presentation

Over one twelve-month period cocaine intake causes clinical distress and impairment.

Three or more of the following within a twelve-month period: 1) more cocaine is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using, and recovering from the effects of cocaine; 7) affects work, social, and leisure functioning; 8) continues to use a cocaine in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

With Physiological Dependence – evidence of tolerance or withdrawal.
Without Physiological Dependence – no evidence of tolerance or withdrawal.
Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.
Sustained Partial Remission – for twelve months or longer does not meet criteria Dependence, but one or more of the criteria for Abuse and Dependence have been met.
On Agonist Therapy – on prescribed agonist medication.
In a Controlled Environment – is in a controlled environment; hospital or inpatient clinic.
Cocaine Abuse is part of the subgroup of Cocaine Use Disorders.
Cocaine is also known as Blow, Crack, Snow, and White Lady.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Cocaine Abuse
Cocaine Intoxication
Cocaine Intoxication
Delirium
Mood Disorder
Psychotic Disorder with Delusions
Psychotic Disorder with Hallucinations
Sexual Dysfunction
Sleep Disorder

Internet Resources
http://www.mentalhealth.com/icd/p22-sb04.html
http://www.update-software.com/Abstracts/AB002023.htm
http://www.med.umich.edu/1libr/aha/aha_cocdep_bha.htm
COCAINE INTOXICATION

Code Number: 292.89
Category: Substance-Related

Behavioral Presentation
Recent intake of cocaine causes maladaptive behavior and psychological effects including blunted affect; hypervigilance, interpersonal sensitivity, anger, anxiety, or tension, changes in sociability, stereotyped behaviors, impaired judgment, work, and social functioning.

One or more of the following shortly after initial intake of cocaine: 1) muscle weakness; shallow or slowed breathing, chest pain or heart arrhythmia; 2) nausea or vomiting; 3) chills or sweating or weight loss; 4) raised or lowered blood pressure; 5) speeded-up or slowed down psychomotor activity; 6) dilated pupils; 7) slowed or rapid heart rate; 8) coma, confusion, involuntary muscular activity, disordered muscle tone, or seizures.

Specifiers, Codes and Comments
With Perceptual Disturbances – auditory, visual illusions; tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).

Cocaine Intoxication is part of the subgroup of Cocaine-Induced Disorders.

From Latin – intoxicare, to poison, + toxicum, poison + -ation, indicating a process or condition.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Cocaine Abuse
Cocaine Dependence
Cocaine Intoxication
Delirium
Mood Disorder
Psychotic Disorder with Delusions
Psychotic Disorder with Hallucinations
Sexual Dysfunction
Sleep Disorder

Internet Resources
http://scc.uchicago.edu/cocaine.htm
http://www.med.umich.edu/1libr/aha/aha_cocintox_bha.htm
COCAINES WITHDRAWAL

Code Number: 292.0  
Category: Substance-Related

Behavioral Presentation

- Stops cocaine intake suddenly after long term use. Affects work, social, and leisure functioning.
- Two or more of the following within a few hours to several days:
  1. fatigue;
  2. unpleasant, vivid dreams;
  3. excessive sleepiness or sleeplessness;
  4. increase in appetite;
  5. heightened or slowed psychomotor activity.

Specifiers, Codes and Comments

- Cocaine Withdrawal is part of the subgroup of Cocaine-Induced Disorders.

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Alternate Diagnostic Presentation

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Generalized Anxiety Disorder  
Cocaine Abuse  
Cocaine Dependence  
Cocaine Intoxication  
Delirium  
Mood Disorder  
Psychotic Disorder with Delusions  
Psychotic Disorder with Hallucinations  
Sexual Dysfunction  
Sleep Disorder

Internet Resources

http://scc.uchicago.edu/cocainewithdrawal.htm
http://www.adjunctcollege.com/imagwithdrawal.html
http://www.buffalo.edu/reporter/vol31/vol31n32/n2.html
CONDUCT

Code Number: 312.8  
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Over twelve months individual has repeatedly violated rules, age-appropriate societal norms or the rights of others.

Three of more of the following with at least one in the previous six months:

- (Aggression) – 1) bullying and threatening; 2) starts fights; 3) has used a weapon(s); 4) physical cruelty to others; 5) physical cruelty to animals; 6) confronted for theft; 7) forced sex on others;
- (Property Destruction) 8) deliberately set fires; 9) deliberately destroyed the property others;
- (Lying or Theft) – 10) broken into buildings, cars, or houses of others; 11) lies and breaks promises for gain or to avoid obligations; 12) stolen valuables and avoiding confrontation;
- (Serious Rule Violation) – 13) before age 13 stays out at night against parent’s authority; 14) ran away from parent(s) overnight twice or more; 15) frequent truancies.

Some symptoms began before age seven.

Specifiers, Codes and Comments

- Childhood Onset Type – at least one characteristic before 10 years of age (Code – 312.81).
- Adolescent-Onset Type – no characteristics before 10 years of age (Code – 312.82).
- Unspecified Onset Type – unknown age of onset (Code – 312.89).
- Mild – few conduct problems causing little harm, i.e, truancy, lying.
- Moderate – a number of conduct problems, i.e., stealing, vandalism.
- Severe – many conduct problems causing harm to others, i.e., rape, battery.

Conduct Disorder is part of a subgroup of Conduct Disorders.

Studies suggest that approximately 1% to more than 10% may suffer from Conduct Disorder.

Degree of Impairment  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action  
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology  
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions  
Always rule out Substance Related Disorders

Adjustment Disorder  
Attention-Deficit/Hyperactivity Disorder  
Child or Adolescent Antisocial Behavior  
Mood Disorder  
Oppositional Defiant Disorder

Internet Resources
http://www.aacap.org/publications/factsfam/conduct.htm
http://www.mentalhealth.com/dis/p20-ch02.html
http://www.aboutourkids.org/aboutour/articles/about_conduct.html
http://www.focusas.com/ConductDisorders.htm
CONVERSION

**Code Number:** 300.11  
**Category:** Somatoform

### Behavioral Presentation
- One symptom or deficit of sensory or voluntary motor function suggesting neurological or other medical problems.
- The symptoms are not limited to pain or sexual problems and produce one or more of the following: 1) medical evaluation; 2) impairs social, work or personal functioning; 3) causes clinical distress.
- Is not part of a multiple pain group and symptoms are not feigned.
- The problem is not related to a person’s culture.
- Individual believes the physiological problems are real.

### Specifiers, Codes and Comments
- **With Motor Symptom or Deficit**
- **With Seizures or Convulsions**
- **With Sensory Symptom or Deficit**
- **With Mixed Presentation**

Conversion Disorder may also be referred to as Conversion Hysteria, Conversion Symptom, or La Belle Indifférence.

### Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- **MODERATE TO SEVERE**
- Severe

### Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- Time off

### Psychopharmacology
- **Medications**
- **Natural Substance**

**Warning:** Medications and natural substances should be used with a doctor’s approval.

### Alternate Diagnostic Presentation

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Body Dysmorphic Disorder
- Borderline Personality
- Dissociative Disorder
- Factitious Disorder
- Histrionic Personality
- Hypochondriasis Disorder
- Malingering
- Panic Disorder
- Pain Disorder
- Psychotic Disorder
- Schizoid Personality
- Sexual Dysfunction
- Somatization Disorder

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Mood Disorder

Internet Resources
http://www.emedicine.com/EMERG/topic112.htm
http://www.mayoclinic.com/invoke.cfm?id=AN00622
http://www.psychnet-uk.com/dsm_iv/conversion_disorder.htm
http://www.medhelp.org/HealthTopics/Conversion_Disorder.html

CYCLOTHYMIC

Code Number: 301.13
Category: Mood

Behavioral Presentation
- For two or more years, but never symptom-free for more than two months; many Hypomaniac Episodes (Pg. 166), being elated; may be irritable, grandiose, talkative, hyperactive, distractible all to a lesser degree than Manic (Pg. 179).
- Many low moods of being depressed, problems with eating, sleeping; feelings of guilt; loss of energy; trouble concentrating; suicidal thoughts all to a lesser degree than Major Depressive Episode (Pg. 200).
- Never free of mood swings longer than two months.
- First two years does not meet the criteria for Manic Episode, Mixed Episode, or Major Depressive Episode.

Specifiers, Codes and Comments
- One year in children and adolescents.
- After two years, Manic Episodes, Mixed Episodes or Major Depressive Episodes may be added the Cyclothymic Disorder.
- Bipolar I Disorder or Bipolar II Disorder (Pg. 131) may be contingent to Cyclothymic Disorder.
- Bipolar II Disorder is part of a subgroup of Bipolar Disorders.
- Studies suggest that the lifetime prevalence is approximately 0.4% to 1% for Bipolar II Disorders.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation
- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Bipolar I with Rapid Cycling
Bipolar II with Rapid Cycling
Borderline Personality
Substance-Induced

Internet Resources
http://www.psychnet-uk.com/dsm_iv/cyclothymic_disorder.htm
http://www.mental-health-today.com/bp/cyclo.htm
http://www.medical-library.org/journals2a/cyclothymic_disorder.htm
http://www.nethealthbook.com/cyclothymicdisorder.html
DELIRIUM DUE TO A GENERAL MEDICAL CONDITION

**Code Number:** 293.0  
**Category:** Delirium, Dementia, Amnestic and Other Cognitive

**Behavioral Presentation**
- Reduced level of consciousness and difficulty focusing, shifting, or sustaining attention.
- **Dementia** does not explain the problem.
- Rapid development over hours to days with a variation in deficit during the day.
- Impairs work or social functioning.

**Specifiers, Codes and Comments**
- Use the condition outline for Delirium.
- Include the name of the Specific General Medical Condition in Axis 1 and III.
- If Vascular Dementia is preexisting, indicate Delirium coded as 290.41. Vascular Dementia with Delirium.
- From Latin – *delirium*, insanity; *delirus*, insane; *delirare*, to turn aside; *de from* + *lira*, a furrow.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- **Severe**

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Acute Stress Disorder
- Generalized Anxiety Disorder
- Brief Psychotic Disorder
- Delirium Due to Multiple Etiologies
- Factitious Disorder
- Malingering
- Mood Disorders
- Psychotic Disorder
- Schizoid Personality
- Schizoaffective Disorder
- Substance-Induced Delirium
- Substance Intoxication Delirium

**Internet Resources**
- [http://www.nurses.info/mental_health_delirium.htm](http://www.nurses.info/mental_health_delirium.htm)
- [http://www.psyweb.com/Mdisord/MoodDis/mdhtagmc.jsp](http://www.psyweb.com/Mdisord/MoodDis/mdhtagmc.jsp)
- [http://www.psychnet-uk.com/dsm_iv/deliriums_symptoms.htm](http://www.psychnet-uk.com/dsm_iv/deliriums_symptoms.htm)
DELIRIUM DUE TO MULTIPLE ETIOLOGIES

Code Number: None

Category: Delirium, Dementia, Amnestic and Other Cognitive Behavior Presentation

Behavioral Presentation
- Reduced level of consciousness and difficulty focusing, shifting, or sustaining attention.
- Dementia does not explain the problem.
- Rapid development over hours to days with a variation in deficit during the day.
- Symptoms have more than one origin as indicated through history, physical exam, or laboratory findings.

Specifiers, Codes and Comments
- See Delirium.
- Code with the specific Delirium and etiologies.
- Indicate specific causes on Axis I.
- Indicate associated physical and substance causes on Axis III.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Acute Stress Disorder
Generalized Anxiety Disorder
Brief Psychotic Disorder
Delirium Due to General Medical Condition
Factitious Disorder
Malingering
Mood Disorders
Psychotic Disorder
Schizoid Personality
Schizoaffective Disorder
Substance withdrawal Delirium
Substance Intoxication Delirium
Substance-Induced Delirium

Internet Resources
http://www.psyweb.com/Mdisord/jsp/deld.jsp
http://www.brandeis.edu/pcc/ental.html
http://xnet.rrc.mb.ca/tomh/disorder.htm
http://www.clevelandclinicmeded.com/diseasemanagement/psychiatry/delirium/delirium.htm
DELIRIUM

Code Number: None

Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation

Reduced awareness of environment, trouble shifting or focusing attention, with cognitive deficit.

One or more of the following: 1) language; 2) memory; 3) orientation; 4) perception; 5) sleep-wake cycle; 6) psychomotor activity and behavior; 7) mood; 8) reasoning.

Specifiers, Codes and Comments

Language – problems with language in speech, i.e., rambling, disjointed, incoherent speech that shifts from one topic to another.

Memory – trouble remembering things with recent events being affected first.

Orientation – date, day, month, year, place, and failure to recognize relatives and friends.

Perception – boundaries are fuzzy, colors are brighter, distorted images, illusions, hallucinations.

Sleep-Wake Cycle – Insomnia, vivid dreams and nightmares, day-night reversal.

Psychomotor Activity and Behavior – increased or decreased physical movement.

Mood – depression or fear.

Reasoning – impaired.

Amnesia – loss of memory.

Retrograde type – loss of memory of events before a time period.

Anterograde type – loss of memory of events after a time period.

Aphasia – language disturbance.

Apraxia – inability to execute normal motor functions.

Agnosia – inability recognizing familiar objects.

Loss of executive functioning – difficulty planning, organizing, sequencing, or abstracting information.

Confusion – slowed thinking, loss of memory or disorientation.

The origin of Delirium is a change in brain functioning with an underlying disease related cause emanating somewhere in the body outside of the Central Nervous System.

Studies suggest that approximately 0.4% adults of 18 and older and 1.1% over the age of 55 may suffer from Delirium. In hospital settings studies suggest a rate between approximately 10% and 30%.

From Latin – delirium, insanity; delirus, insane; delirare, to turn aside; de from + lira, a furrow.

Internet Resources

http://www.mentalhealth.com/dis/p20-or01.html
http://www.aafp.org/afp/20030301/1027.html
http://www.henryfordhealth.org/15330.cfm
Delusional

**Code Number:** 297.1  
**Category:** Schizophrenia and Other Psychotic Disorders

**Behavioral Presentation**
- For one month or more experiences non-bizarre delusions.
- **Schizoid Personality** criteria “A”.
- Functioning is not significantly impaired beyond the current delusions.
- **Mood Episodes** are briefly present during the delusions.

**Specifiers, Codes and Comments**
- **Erotomanic Type** – believes someone, usually of a higher status, is in love with them.
- **Grandiose Type** – inflated sense of worth, knowledge, power, self-identifies as a deity or famous person.
- **Jealous Type** – believes their sexual partner is unfaithful.
- **Prosecutory Type** – believes they, or someone to whom they are close, is being mistreated.
- **Somatic Type** – believes they have a physical defect or general medical condition.
- **Mixed Type** – two or more of the delusional beliefs.
- **Unspecified Type** – unable to identify the delusions.

**Degree of Impairment**
- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

**Suggested Course of Action**
- ☒ Medical Attention
- ☒ Therapy/Counseling
- ☒ Support Group
- ☒ Special Needs
- Change of Location
- ☒ Time off

**Psychopharmacology**
- ☒ Medications
- ☒ Natural Substance
  - None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Body Dysmorphic Disorder  
Brief Psychotic Disorder  
Depressive Disorder Not Otherwise  
Factitious Disorder With Predominantly Psychological Hypochondriasis  
Mood Disorder with Psychotic Features  
Obsessive-Compulsive Disorder  
Paranoid Personality  
Psychotic Disorder Not Otherwise Specified  
Schizoid Personality  
Schizoaffective Disorder  
Shared Psychotic Disorder  
Shared Psychotic Disorder Not Otherwise Specified  
Specified Bipolar Disorder Not Otherwise Specified
Internet Resources
http://www.emedicine.com/med/topic3479.htm
http://www.psychnet-uk.com/dsm_iv/brief_psychotic_episode.htm
http://www.wrongdiagnosis.com/b/brief_psychotic_disorder/intro.htm
DEMENTIA

Code Number: None

Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation
Memory loss, cognitive deficits, non prominent attention shifting and focusing, usually generalized in the Central Nervous System, relatively fixed condition that is non-volatile.

Specifiers, Codes and Comments
Memory – trouble remembering things with recent events being affected first.
Decline – overall decline in individual’s level of functioning.
Agnosia – inability to recognize or identify familiar objects.
Aphasia – economy of language due to inability to remember words.
Apraxia – inability to perform basic motor-functioning acts.
Loss of Executive Functioning – self-care or thought organization.

Studies suggest that approximately 1.4% to 1.6% between the ages of 65-69 and 16% to 25% for those over the age of 85 may suffer from Dementia.

From Latin – dementare, to drive mad; from, de from + mens mind + -ia, indicating a condition or quality.

Degree of Impairment

Very Mild

Mild

Mild to Moderate

Moderate

Moderate to Severe

Severe

Suggested Course of Action

Medical Attention

Therapy/Counseling

Support Group

Special Needs

Change of Location

Time off

Psychopharmacology

Medications

Natural Substance

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia Due to Other General Medical Conditions
Dementia of the Alzheimer’s Type
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Withdrawal
Substance Intoxication
Substance-Induced Dementia
Vascular Dementia.
Internet Resources
http://www.neurologychannel.com/dementia/
http://www.mentalhealth.com/dis/p20-or05.html
http://www.dementia-voice.org.uk/
http://www.americangeriatrics.org/education/forum/dementia.shtml
DEMENTIA DUE TO CREUTZFELDT-JAKOB DISEASE

**Code Number:** 294.1x

**Category:** Delirium, Dementia, Amnestic and Other Cognitive

**Behavioral Presentation**

- Deficits of thinking caused by Creutzfeldt-Jakob Disease evidenced by inability to learn new information or remember previously learned information.

- *One or more of the following:* 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

**Specifiers, Codes and Comments**


- See Dementia.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.

- From Latin – dementare, to drive mad; from, de from + mens mind + -ia, indicating a condition or quality.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Cognitive Disorder
- Delirium
- Dementia of the Alzheimer’s Type
- Dementia Due to Other General Medical Conditions
- Factitious Disorder
- Major Depressive
- Malingering
- Mental Retardation
- Schizophrenia
- Substance Intoxication
- Substance Withdrawal
Substance-Induced Dementia

**Internet Resources**
http://www.psyweb.com/Mdisord/jsp/CJdisease.jsp
http://jnnp.bmjournals.com/cgi/content/abstract/49/2/163
http://www.merck.com/mmhe/sec06/ch083/ch083c.html
DEMENTIA DUE TO HEAD TRAUMA

Code Number: 294.1x
Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation
- Deficits of thinking caused by head trauma evidenced by an inability to learn new information or remember previously learned information.
- One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
- Without Behavioral Disturbance (Code – 294.10).
- With Behavioral Disturbance (Code – 294.11).
- See Dementia
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.
- From Latin – dementare, to drive mad; from, de from + mens mind + -ia, indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive Disorder
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

Internet Resources
http://www.emedicine.com/med/topic3152.htm
http://www.neurocrecer.com/articles/2002-0.htm
http://www.emedicinehealth.com/articles/38577-6.asp
http://jnnp.bmjjournals.com/cgi/content/abstract/62/2/119
DEMENTIA DUE TO HIV DISEASE

Code Number: 294.1x  
Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation
- Deficits of thinking caused by HIV Disease evidenced by inability to learn new information or remember previously learned information.
- One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
- Without Behavioral Disturbance (Code – 294.10).
- With Behavioral Disturbance (Code – 294.11).
- See Dementia.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.
- From Latin – dementare, to drive mad; from, de from + mens mind + -ia, indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

Internet Resources
http://www.emedicine.com/med/topic3151.htm
http://www.geocities.com/~jenniferjensen/QUESTIONS/dementia.htm
DEMENTIA DUE TO HUNTINGTON'S DISEASE

Code Number: 294.1x

Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation

- Deficits of thinking caused by Huntington’s Disease evidenced by inability to learn new information or remember previously learned information.
- One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments

- Without Behavioral Disturbance (Code – 294.10).
- With Behavioral Disturbance (Code – 294.11).
- See Dementia.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.
- From Latin – dementare, to drive mad; from, de from + mens mind + -ia, indicating a condition or quality.

Degree of Impairment

<table>
<thead>
<tr>
<th>Very Mild</th>
<th>Mild</th>
<th>Mild to Moderate</th>
<th>Moderate</th>
<th>Moderate to Severe</th>
<th>Severe</th>
</tr>
</thead>
</table>

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

**Internet Resources**
http://www.psyweb.com/Mdisord/jsp/demd.jsp
http://www.otdirect.co.uk/huntingtons.html
http://memory.ucsf.edu/Education/education_hd.html
http://www.bcm.edu/neurol/struct/hunting/huntp1.html
DEMENTIA DUE TO MULTIPLE ETIOLOGIES

Code Number: None
Category: Delirium, Dementia, Amnestic and Other Cognitive Behaviors

Behavioral Presentation
Deficits of thinking caused from multiple diseases evidenced by inability to learn new information or remember previously learned information.

One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
Without Behavioral Disturbance (Code – 294.10).
With Behavioral Disturbance (Code – 294.11).
See Dementia.
Decline in mental functioning is gradual and worsens over time.
Not due to other causes of Dementia.
Symptoms do not exist solely during Delirium.
If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
Code underlying specific disease on Axis III.
From Latin – *dementare*, to drive mad; from, *de* from + *mens* mind + *-ia*, indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
  - None Suggested
Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

Internet Resources
http://www.behavenet.com/capsules/disorders/demme.htm
http://www.psych.org/psych_pract/treatg/pg/pg_delirium_2.cfm
DEMENTIA DUE TO PARKINSON’S DISEASE

**Code Number:** 294.1x  
**Category:** Delirium, Dementia, Amnestic and Other Cognitive

**Behavioral Presentation**
- Deficits of thinking caused by Parkinson’s Disease evidenced by inability to learn new information or remember previously learned information.
- *One or more of the following:* 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

**Specifiers, Codes and Comments**
- **Without Behavioral Disturbance** (Code – 294.10).
- **With Behavioral Disturbance** (Code – 294.11).
- See Dementia.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.
- From Latin – *dementare,* to drive mad; from, *de* from + *mens* mind + -ia, indicating a condition or quality.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

**Internet Resources**
http://www.emedicine.com/med/topic3110.htm
http://www.merck.com/mrkshared/mm_geriatrics/sec5/ch40.jsp
http://medweb.bham.ac.uk/http/depts/clin_neuro/teaching/tutorials/parkinsons/parkinsons1.html
http://www.mentalneurologicalprimarycare.org/content_show.asp?c=16&fid=1356&fc=005107
DEMENTIA DUE TO PICK’S DISEASE

Code Number: 294.1x Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation
- Deficits of thinking caused by Pick’s Disease evidenced by inability to learn new information or remember previously learned information.
- *One or more of the following:* 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
- **Without Behavioral Disturbance** (Code – 294.10).
- **With Behavioral Disturbance** (Code – 294.11).
- See Dementia.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- If the disorder is superimposed on Dementia of the Alzheimer’s Type or Vascular Dementia use (Code – 290.10) on Axis I and (Code – 046.1) on Axis III.
- Code underling specific disease on Axis III.
- From Latin – *dementare,* to drive mad; from, *de from + mens mind + -ia,* indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

Internet Resources
http://www.pdsog.org.uk/articles/GaA-1.htm
http://www.healthcentral.com/mhc/top/000744.cfm
DEMENTIA OF THE ALZHEIMER’S TYPE

Code Number: x

Category: Delirium, Dementia, Amnestic and Other Cognitive Presentation

Behavioral Presentation
- Can not learn new information or can not recall previously learned information.
- Decline in mental functioning begins slowly and worsens over time and is does not occur solely during Delirium (Pg. 154).
- One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
- With Early Onset – at 65 years or younger
- With Late Onset – at 65 years or older
- With Delusions – over 65 (Code – 290.20) under 65 (Code – 290.12)
- With Depressed Mood – over 65 (Code – 290.21) under 65 (Code – 290.13)
- With Delirium – over 65 (Code – 290.3) under 65 (Code – 290.11)
- Uncomplicated – over 65 (Code – 290.0) under 65 (Code – 290.10)
- Without Behavioral Disturbance (Code – 294.10)
- With Behavioral Disturbance (Code – 294.11)
- See Dementia.
- Add Alzheimer’s Disease (Code – 331.0) on Axis III.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other causes of Dementia.
- Symptoms do not exist solely during Delirium.
- From Latin – dementare, to drive mad; from, de from mens mind + -ia, indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia

**Internet Resources**
http://www.psychnet-uk.com/dsm_iv/alzheimers_dementia.htm
DEPENDENT PERSONALITY

Code Number: 301.6
Category: Personality

Behavioral Presentation

_Five or more of the following:_ 1) everyday decisions require a strong need for advice and reassurance; 2) need others to be responsible for major life problems and areas; 3) difficulty expressing disagreement as a result of being afraid of loss of approval from others; 4) as a result of low self-confidence is unable to start or follow though with projects; 5) will do almost anything to gain support of others; 6) being alone leads to fears of an inability to take care of one’s self, leading to discomfort or helplessness; 7) need to immediately replace lost relationships; 8) unrealistic fears of abandonment.

Specifiers, Codes and Comments

- Personality problems begin in early adult life
- Personality Disorders are grouped in clusters. Dependent Personality is part of Cluster “C” Disorders.
- Studies suggest that Dependent Personality Disorder is among the most common presentations in psychiatric settings.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

- Agoraphobia
- Avoidant Personality
- Borderline Personality
- Histrionic Personality
- Mood Disorder
- Panic Disorder

Internet Resources

http://www.mentalhealth.com/dis/p20-pe09.html
http://www.toad.net/~arcturus/dd/depend.htm
http://cms.psychologytoday.com/conditions/dependent.html
DEPERSONALIZATION

Code Number: 300.6
Category: Dissociative

Behavioral Presentation
- Feeling detached from one’s own body.
- Observing one’s self from outside one’s body, as if in a dream.
- Knows that what is happening is not really happening.

Specifiers, Codes and Comments
- Depersonalization Disorder is referred to Depersonalization Neurosis.

Degree of Impairment  | Suggested Course of Action | Psychopharmacology
---|---|---
Very Mild             | Medical Attention          | Medications
Mild                  | Therapy/Counseling         | Natural Substance
Mild to Moderate      | Support Group              | None Suggested
Moderate              | Special Needs              | Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe    | Change of Location         |
Severe                | Time off                   |

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Acute Stress Disorder
Mood Disorder
Panic
Posttraumatic Stress Disorder
Social Phobia
Specific Phobia
Schizoid Personality

Internet Resources
http://www.merck.com/mmhe/sec07/ch106/ch106e.html
http://psychcentral.com/disorders/sx47.htm
http://www.wrongdiagnosis.com/d/depersonalization_disorder/intro.htm
DEVELOPMENTAL COORDINATION

Code Number: 315.4

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
Motor coordination in daily living is markedly less than expected for the individual’s age and intelligence exhibited by general clumsiness, inadequate sports ability, poor hand writing, or early developmental problems with sitting, crawling or walking.

Motor coordination problem impairs academic achievement and daily living.

Specifiers, Codes and Comments
Developmental Coordination Disorder is part of the subgroup of Motor Skill Disorders.
Code all sensory deficits or General Medical Conditions on Axis III.
Studies suggest that approximately 6% of children ages 5 to 11 may suffer from Developmental Coordination Disorder.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Attention-Deficit/Hyperactivity Disorder
Mental Retardation
Pervasive Developmental Disorder

Internet Resources
http://www.psychnet-uk.com/dsm_iv/developmental_coordination_disorder.htm
http://www.brightfutures.org/physicalactivity/issues_concerns/10.html
http://access.autistics.org/information/motor/dyspraxia.html
DISORDER OF WRITTEN EXPRESSION

**Code Number:** 315.2

**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**
- Writing ability is markedly less than expected given the individual’s age, intelligence and education.
- Writing problems, including grammatical errors and paragraph organization, impede academic achievement and daily living.

**Specifiers, Codes and Comments**
- Learning Disorders were formerly known as Academic Skills Disorders.
- Disorder of Written Expression is part of a subgroup of Learning Disorders.
- Code all sensory deficits or General Medical Conditions on Axis III.
- Studies suggest that approximately 5% of all public school students may suffer from Learning Disorders.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Developmental Coordination
Mental Retardation
Pervasive Development
Pyromania

**Internet Resources**
http://www.athealth.com/Consumer/disorders/WrittenExp.html
http://www.umm.edu/ency/article/001543.htm
http://www.behavenet.com/capsules/disorders/writtenexpdis.htm
DISSOCIATIVE AMNESIA

Code Number: 300.12          Category: Dissociative

Behavioral Presentation
- One episode of an inability to remember personal or important information.
- Information is associated with stress and trauma.
- Has forgotten something important that is more than ordinary forgetting.
- Problem is not the result of normal forgetfulness or fatigue.

Specifications, Codes and Comments

Localized – recalls no events during a particular time period.
Selective – certain portions of a period of time are forgotten.
Generalized – all lifetime experiences have been forgotten.
Continuous – all events from a given time to the present are forgotten.
Systematized – types of information are forgotten: family, work, school.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Acute Stress Disorder
Delirium
Dementia
Depersonalization
Dissociative Fugue
Dissociative Identity
Malingering
Posttraumatic Stress Disorder
Somatization Disorder

Internet Resources
http://www.psychnet-uk.com/dsm_iv/dissociative_amnesia.htm
http://www.merck.com/mrkshared/mmanual/section15/chapter188/188b.jsp
http://psychcentral.com/disorders/sx46.htm
http://www.nami.org/Content/ContentGroups/Helpline1/Dissociative_Disorders.htm
DISSOCIATIVE FUGUE

Code Number: 300.13  
Category: Dissociative

Behavioral Presentation

Travels away from home–suddenly–and is unable to remember important details about the past.
Confused about identity or assumes new identity, partial or complete.

Specifiers, Codes and Comments

Dissociate Fugue was formerly referred to as Psychogenic Fugue.

From Latin – fuga, a flight.

Degree of Impairment  
Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action
Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology
Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Depersonalization Disorder
Disorder of Written Expression
Dissociative Identity
Malingering
Manic Episode
Schizoid Personality

Internet Resources
http://www.athealth.com/Consumer/disorders/Dissociative.html
http://healthinmind.com/english/dissocamn.htm
http://www.healthatoz.com/healthatoz/Atoz/ency/dissociative_disorders.jsp
http://www.petsandpeople.org/APNA/APNA%202/sld016.htm
DISSOCIATIVE IDENTITY

**Code Number:** 300.14

**Category:** Dissociative

**Behavioral Presentation**

- Two or more identities or personalities, each having its own thinking, sensing, pattern of behavior, relating to self and environment.
- Two or more personalities assume control.
- Normal forgetfulness does not explain the behavior.

**Specifiers, Codes and Comments**

- Dissociative Identity Disorder was formerly known as Multiple Personality Disorder.
- Each personality may have its own name and psychiatric problems.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Generalized Anxiety Disorder
Bipolar I Disorder
Borderline Personality
Depersonalization Disorder
Dissociative Fugue
Dissociative Amnesia
Factitious Disorder
Histrionic Personality
Malingering
Personality Disorder
Posttraumatic Stress Disorder
Schizoid Personality
Somatization Disorder

**Internet Resources**

http://www.sidran.org/didbr.html
http://www.healthubs.com/dissociative/
http://www.psycom.net/mchugh.html
http://skepdic.com/mpd.html
DYSPAREUNIA

**Code Number:** 302.76  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Genital pain with sexual intercourse.
- Not due to inadequate lubrication of Vaginismus (Pg. 302).
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

**Specifiers, Codes and Comments**
- *Lifelong Type* – has existed for the individual’s entire sexual life.
- *Acquired Type* – exists for periods of time.
- *Generalized Type* – exists with any partner or sexual activity.
- *Situational Type* – exists only with certain partners or situations.
- *Due to Psychological Factors* – only psychological issues.
- *Due to Combined Factors* – both psychological and physical issues.

Dyspareunia is part of the Sexual Pain Disorders which are a subgroup of Sexual Dysfunctions. From Greek – dys, bad or abnormal + *para*, beside, + *eune*, a bed, + *-ia*, indicating a condition or quality.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Generalized Anxiety Disorder
Somatization Disorder
Vaginismus

**Internet Resources**
- http://www.dyspareunia.org/
- http://www.netdoctor.co.uk/sex_relationships/facts/painfulintercourse.htm
DYSTHYMIC

Code Number: 300.4 Category: Mood

Behavioral Presentation
- Two or more years for most of those days the individual has depression, problems with eating, sleeping, feelings of guilt, loss of energy, trouble concentrating, suicidal thoughts.
- Symptoms are never gone for more than two consecutive months during the two-year period.
- Major Depressive Episode does not exist for first two years.
- Less severe as Major Depressive Disorder, Single Episode or Recurrent Episodes.
- No Manic Episodes, Hypomanic Episodes, or Mixed Episodes.

Specifiers, Codes and Comments
- **Early Onset** – begins by the age of 20.
- **Late Onset** – begins by the age of 21 or later.
- **With Atypical Features** – for most of two years the full criteria is not meet for a Major Depressive Episode.
- See Major Depressive Episode for coding “x” types.
- Dysthymic is part of a subgroup of Depressive Disorders.
- A two-month period must elapse between episode where Major Depressive Episodes have not occurred.
- For children the mood may be irritability, required for one year.
- Does not exist alone with a psychosis such as Schizophrenia or Delusional Disorders.
- Major Depressive Disorder can precede Dysthymic Disorder if it has been in remission for two consecutive months.
- Dysthymic Disorder, if it lasts for two or more years, may precede Major Depressive Disorder.
- Studies suggest that the lifetime risk is approximately 3.0% for Dysthymic Disorder.
- From Greek – *dys*, bad or abnormal + *thymos*, spirit.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
  - Moderate
  - Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Cyclothymic Disorder
Major Depressive, Recurrent
Major Depressive Disorder
Single Episode
Psychotic Disorder
Internet Resources
http://www.mentalhealth.com/dis/p20-md04.html
http://www.psychologyinfo.com/depression/dysthymic.htm
http://www.allaboutdepression.com/dia_04.html
ENCOPRESIS

Code Number: None

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- Repeatedly passes feces, accidentally or on purpose, inappropriately, i.e., clothing, floor, bed, pool, shower.
- Once per month for at least three months.
- Four years of age or more.

Specifiers, Codes and Comments
- With Constipation and Overflow Incontinence (Code – 787.6).
- Without Constipation and Overflow Incontinence (Code – 307.7).
- Encopresis is part of a subgroup of Elimination Disorders.
- Studies suggest that approximately 1% of 5-year-old children may suffer from Encopresis.
- From Greek – en, in + kópros, excrement + -esis, on the model of enuresis.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.keepkidshealthy.com/welcome/conditions/encopresis.html
http://www.angelfire.com/biz4/Encopresis/
http://kidshealth.org/parent/emotions/behavior/encopresis.html
http://www.med.umich.edu/1libr/yourchild/encopre.htm
ENURESIS

**Code Number:** 307.6  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**
- Repeatedly passes urine, accidently or on purpose, inappropriately, i.e., clothing, floor, bed, pool, shower.
- Occurs twice per week for three consecutive months.
- The individual must be five years of age or more.

**Specifiers, Codes and Comments**
- **Nocturnal Only** – passes urine only at night.
- **Diurnal Only** – passes urine only during waking hours.
- **Nocturnal and Diurnal** – passes urine during the waking hours and night.
- Enuresis is part of a subgroup of Elimination Disorders.
- Studies suggest that approximately 5% to 10% of 5-year-old children, 3% to 5% of 10-year-old children, and 1% of those 15 years old or older may suffer from Enuresis.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- **Moderate to Severe**
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

**Internet Resources**
- [http://www.stanford.edu/~dement/enuresis.html](http://www.stanford.edu/~dement/enuresis.html)
EXHIBITIONISM

Code Number: 302.4
Category: Sexual and Gender Identity

Behavioral Presentation
- Strong sexual impulse, fantasy or behavior involving exposure of genitals to unsuspecting people.
- The behavior takes place for six months or more.

Specifiers, Codes and Comments
- Exhibitionism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular paraphilia.
- It is estimated that 50% of those seen for a paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Dementia
Exhibitionism
Fetishism
Frotterism
Gender Identity Disorder
Manic Episode
Mental Retardation
Pedophilia
Schizophrenia
Transvestic Fetishism
Voyeurism

Internet Resources
http://allpsych.com/disorders/paraphilias/exhibitionism.html
http://www.psychdirect.com/forensic/Criminology/para/exhibitionism.htm
http://www.merck.com/mrkshared/mmanual/section15/chapter192/192d.jsp
http://www.healthyplace.com/Communities/Sex/sexpsych/sex_problems/
EXPRESSIVE LANGUAGE

Code Number: 315.31  
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Expressive language development is lower than nonverbal intellectual capacity and receptive language development. Problems understanding sentences, words, specific classes of words, i.e., spatial terms.

May have materially limited vocabulary; makes errors of tense; has poor word recall or create shorter or less complex sentences than is developmentally expected.

Education, occupational achievement or social communication is interrupted.

Specifiers, Codes and Comments

Expressive Language Disorder is part of a subgroup of Communication Disorders.

Code all sensory deficits or neurological conditions on Axis III.

Mental retardation, environmental deprivation, speech-motor or sensory deficit may worsen the individual’s problem.

Developmental language delays are more common than acquired language delays.

Studies suggest that approximately 10% to 15% of children under the age of three and 3% to 7% of school age children may suffer from Expressive Language Disorder.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions  
Always rule out Substance Related Disorders

Autistic
Mental Retardation
Mixed Receptive-Expressive Language
Pervasive Developmental
Selective Mutism
Disorder of Written Expression

Internet Resources
http://www.psychnet-uk.com/dsm_iv/expressive_language_disorder.htm
http://psychcentral.com/disorders/sx41.htm
http://www.isn.net/~jypsy/explangu.htm
http://www.umm.edu/ency/article/001544.htm
FACTITIOUS

**Code Number:** None

**Category:** Factitious

**Behavioral Presentation**
- Individual fakes being ill, assumes a sick role, has multiple surgeries, or seeks hospital admissions for the purpose of receiving medical attention.
- The individual has no actual illness, pain, or discomfort.
- Gaining compensation or avoiding responsibilities is not the motive for obtaining medical attention.

**Specifiers, Codes and Comments**
- *With Predominantly Psychological Signs and Symptoms* – only psychological presentations (Code – 300.19).
- *With Predominantly Physical Signs and Symptoms* – only physiological presentations (Code – 300.16).
- *Ganser’s Syndrome* may appear to be Factitious Disorder because the individual intentionally gives false answers to simple questions.
- Factitious Disorder may also be called Münchausen Syndrome, Pathomimicry or Hospital Hopper Syndrome.
- Studies suggest that approximately 1% of hospital patients who have a psychiatric consult may suffer from Factitious Disorder.
- From Latin – *facticius*, artificial or made; *facere* to make

**Degree of Impairment**

<table>
<thead>
<tr>
<th>Degree</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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</thead>
<tbody>
<tr>
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<td>Time off</td>
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</tbody>
</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

- Antisocial Personality
- Borderline Personality
- Brief Psychotic Disorder
- Dementia
- Dependent Personality
- Ganser’s Syndrome
- Histrionic Personality
- Malingering
Schizoid Personality
Somatization Disorder

Internet Resources
http://ourworld.compuserve.com/homepages/Marc_Feldman_2/
http://www.priory.com/psych/factitious.htm
http://www.psychnet-uk.com/dsm_iv/factitious_disorder.htm
FACTITIOUS BY PROXY

Code Number: 300.19  Category: Factitious

Behavioral Presentation

- The individual, usually the female parent or caregiver, intentionally makes a child ill to the point of requiring medical intervention.
- The individual gets medical attention through the attention given to the sick child.

Specifiers, Codes and Comments

- Factitious Disorder by Proxy may also be called Münchausen Syndrome by Proxy.
- Since the illness is caused intentionally, the caregiver’s behavior may be extremely dangerous and may ultimately lead to the death of the child.
- Some clinicians believe that crib death—Sudden Infant Death Syndrome (SIDS)—is, in some cases, a result of Factitious Disorder by Proxy.
- From Latin—facticius, artificial or made; facere to make

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Factitious Disorder
Malingering
Shared Psychotic Disorder

Internet Resources

http://www.mbpexpert.com/
http://www.psychnet-uk.com/dsm_iv/factitious_disorder_by_proxy.htm
http://www.msbp.com/ericmart.htm
http://www.chclibrary.org/micromed/00047830.html
FEEDING DISORDER OF INFANCY OR EARLY CHILDHOOD

Code Number: 307.59

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

- With onset prior to the age of six, for a month or more, repeatedly fails to eat adequately; does not gain or lose weight.
- Not a gastrointestinal illness or general medical condition.

Specifiers, Codes and Comments

- Feeding and Eating Disorders of Infancy or Early Childhood is part of a subgroup of Feeding and Eating Disorders of Infancy or Early Childhood.
- Studies suggest that approximately 1% to 5% of pediatric hospital admissions may suffer from Feeding and Eating Disorders of Infancy or Early Childhood.

Degree of Impairment

| Very Mild |
| Mild |
| Mild to Moderate |
| Moderate |
| Moderate to Severe |
| Severe |

Suggested Course of Action

| Medical Attention |
| Therapy/Counseling |
| Support Group |
| Special Needs |
| Change of Location |
| Time off |

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Rumination

Internet Resources

http://www.shands.org/health/information/article/001540.htm
http://www.drkoop.com/ency/article/001540.htm
http://www.ehendrick.org/healthy/001540.htm
http://www.geocities.com/abuselink/childhood_disorders.html
FEMALE ORGASMIC

**Code Number:** 302.73 **Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Adequate sexual excitement does not bring about an orgasm.
- Lack of orgasm is persistent and repeated in terms of being delayed or absent.
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

**Specifiers, Codes and Comments**
- **Lifelong Type** – has existed for the individual’s entire sexual life.
- **Acquired Type** – exists for periods of time.
- **Generalized Type** – exists with any partner or sexual activity.
- **Situational Type** – exists only with certain partners or situations.
- **Due to Psychological Factors** – only psychological issues.
- **Due to Combined Factors** – both psychological and physical issues.

Female Orgasmic Disorder was formerly referred to as Inhibited Female Orgasm.
Female Orgasmic Disorder is a part of the Orgasmic Disorders which are a subgroup of Sexual Dysfunctions.

Studies suggest that approximately 30% of women are in-orgasmic.

**Degree of Impairment**
- Very Mild
  - Mild
  - Mild to Moderate
  - Moderate
  - Moderate to Severe
  - Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*
*Always rule out Substance Related Disorders*

Somatization Disorder

**Internet Resources**

http://www.coolnurse.com/orgasm_female.htm
http://www.psychnet-uk.com/dsm_iv/female оргasmic_disorder.htm
http://www.athealth.com/Consumer/disorders/Sexual.html
http://www.merck.com/mrkshared/mmanual/section18/chapter243/243c.jsp
FETISHISM

**Code Number:** 302.81  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Strong sexual impulse, fantasy or behavior involving inanimate objects.
- The behavior takes place for six months or more.

**Specifiers, Codes and Comments**
- Fetishism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular Paraphilia.
- It is estimated that 50% of those seen for a Paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Dementia
- Exhibitionism
- Frotteurism
- Gender Identity Disorder
- Manic Episode
- Mental Retardation
- Pedophilia
- Schizophrenia
- Transvestic Fetishism
- Voyeurism

**Internet Resources**
- http://www.uihealthcare.com/topics/mentalemotionalhealth/ment3145.html
FROTTEURISM

Code Number: 302.89  
Category: Sexual and Gender Identity

Behavioral Presentation

- Strong sexual impulse, fantasy, or behavior involving touching and rubbing against a person without the other person’s consent.
- The behavior takes place for six months or more.

Specifiers, Codes and Comments

- Frotteurism is in a subgroup of Paraphilias.
- Frotteurism is also referred to as Frottage.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular Paraphilia.
- Studies suggest that 50% of those seen for a Paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.

Degree of Impairment  

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</table>

Alternate Diagnostic Presentation

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Dementia
Exhibitionism
Fetishism
Gender Identity Disorder
Manic Episode
Mental Retardation
Pedophilia
Schizoid Personality
Transvestic Fetishism
Voyeurism

Internet Resources

http://www.psychnet-uk.com/dsm_iv/frotteurism.htm
http://www.medical-library.org/journals/mddx/frotteurism/1_touching.htm
http://allpsych.com/disorders/paraphilias/frotteurism.html
GENDER IDENTITY

Code Number: 302.x

Category: Sexual and Gender Identity

Behavioral Presentation

- Strong identification to the opposite sex.
- States a desire to be the opposite sex; often presents as opposite sex; wants to live and be treated as the opposite sex; believes feelings and reactions are those of the opposite sex; believes their gender is wrong; dwells on hormones, surgery, and physical attributes to change genders; the individual believes he or she was born the wrong gender.
- Preoccupied with getting rid of primary and secondary sex characteristics via operations and hormones. In females it may be referred to as the Diana Complex.
- Is not an intersex condition: ambiguous genitalia.

Specifiers, Codes and Comments

- Gender Identity Disorder in Adolescents and Adults (302.85).
- Gender Identity Disorder in Children (302.6).
- Sexually Attracted to Males – for those who are mature.
- Sexually Attracted to Females – for those who are mature.
- Sexually Attracted to Males and Females – for those who are mature.
- Sexually Attracted to Neither Males or Females – for those who are mature.
- In children: Boys – belief that the penis or testes are disgusting with a desire for them to disappear, avoidance of rough play and stereotypical male toys, games, and activities.
- Girls – stands while urinating, believes she will grow a penis, does not want to grow breasts or menstruate, and avoids feminine clothing and play.
- Gender Identity Disorder is part of a subgroup of Paraphilias.
- The behavior takes place for six months or more.
- Studies suggest that approximately 1 in 30,000 adult males and 1 in 100,000 adult females may seek sex-reassignment surgery.

Degree of Impairment | Suggested Course of Action | Psychopharmacology
---|---|---
Very Mild | Medical Attention | Medications
Mild | Therapy/Counseling | Natural Substance
|Mild to Moderate | Support Group | None Suggested
Moderate | Special Needs | Warning: Medications and natural substances should be used with a doctor’s approval.
Severe | Change of Location | Time off

Altered Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Transvestic Fetishism
Schizoid Personality

Internet Resources
http://www.leaderu.com/jhs/rekers.html
GENERALIZED ANXIETY

**Behavioral Presentation**

- Over six months, for half that time, individual has high anxiety and worries over events or activities.
- Three or more of the following symptoms for half the days over six months: 1) restless, edgy, keyed up; 2) tires easily; 3) trouble concentrating; 4) irritable, increased muscle tension; 5) trouble sleeping.

**Specifiers, Codes and Comments**

- Generalized Anxiety Disorder also includes Overanxious Disorder of Childhood.
- Studies suggest that approximately 3% to 5% of the adult population may suffer from Generalized Anxiety Disorder.
- Because the symptoms are common the condition may be difficult to recognize.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

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</table>

**Always rule out** General Medical Conditions

**Always rule out** Substance Related Disorders

**Alternate Diagnostic Presentation**

- Adjustment Disorder
- Anorexia
- Hypochondriasis
- Mood Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder
- Posttraumatic Stress Disorder
- Psychotic Disorder
- Separation Anxiety Disorder
- Social Phobia
- Somatization Disorder

http://www.athealth.com/Consumer/disorders/GenderIden.html
http://www.genderpsychology.org/
http://www.merck.com/mrkshared/mmanual/section15/chapter192/192c.jsp
Internet Resources
http://www.mentalhealth.com/dis/p20-an07.html
http://www.anxietynetwork.com/gahome.html
http://www.burnsurvivorsttw.org/articles/gad.html
http://www.nimh.nih.gov/HealthInformation/gadmenu.cfm
HALLUCINOGEN ABUSE

Code Number: 305.30
Category: Substance-Related

Behavioral Presentation
Over one twelve-month period hallucinogen intake causes clinical distress and impairment.
One or more of the following: 1) affects work, social, and leisure functioning; 2) continues to use hallucinogen in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of hallucinogen; 5) hallucinogen abuse leads to legal problems; 6) continues use despite knowing the effects on work, social and personal problems

Specifiers, Codes and Comments
Hallucinogen Dependence is part of the subgroup of Hallucinogen Use Disorders.
Hallucinogens may consist of Phenylalkylamines and Indole Alkaloids
Hallucinogens may also be known as Bufotenin, Harmine, LSD, Psilocybin, DMT, Ibogaine Acid, Myristin, Ololiuqui Mescaline, PCP, Psychodysleptic, Psycholytic, Psychotomimetic, Amanita Muscaria, Fly Agaric, Magic Mushroom, Morning Glory, Muscimol, Phencyclidine, and Teonanactyl.

From Latin – alucinari, to wander in the mind + Greek – genes, born or produced.

Degree of Impairment

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Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Delirium
Hallucinogen Dependence
Hallucinogen Intoxication
Hallucinogen Persisting Perception
Mood Disorder
Psychotic Disorder with Delusions
Psychotic Disorder with Hallucinations

Internet Resources
http://unthsc-dl.slis.ua.edu/clinical/alcohol/hallucinogens.htm
http://www.addictions.org/lsd.htm
http://www.health.org/govpubs/phd642/
**HALLUCINOGEN DEPENDENCE**

**Code Number:** 304.50  
**Category:** Substance-Related

### Behavioral Presentation

- Over one twelve-month period hallucinogen intake causes clinical distress and impairment.
- Three or more of the following within a twelve-month period: 1) more hallucinogens are needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using and recovering from the effects of hallucinogens; 7) effects work, social, and leisure functioning; 8) continues to use a hallucinogens in spite of their negative physical and psychological effects.

### Specifiers, Codes and Comments

- With Physiological Dependence – evidence of tolerance or withdrawal.
- Without Physiological Dependence – no evidence of tolerance or withdrawal.
- Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
- Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
- Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.
- Sustained Partial Remission – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.
- On Agonist Therapy – on prescribed agonist medication.
- In a Controlled Environment – is in a controlled environment; hospital or inpatient clinic.

Hallucinogen Dependence is part of the subgroup of Hallucinogen Use Disorders.

*From Latin – alucinari, to wander in the mind + Greek – genes, born or produced.*

### Degree of Impairment

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### Suggested Course of Action

- **Always rule out** General Medical Conditions
- **Always rule out** Substance Related Disorders

Generalized Anxiety Disorder  
Delirium  
Hallucinogen Abuse  
Hallucinogen Intoxication  
Hallucinogen Persisting Perception  
Mood Disorder
Psychotic Disorder with Delusions
Psychotic Disorder with Hallucinations

Internet Resources
http://www.med.umich.edu/1libr/aha/aha_halludep_bha.htm
http://www.mentalhealth.com/dis/p20-sb05.html
HALLUCINOGEN INTOXICATION

Code Number: 292.89.00

Category: Substance-Related

Behavioral Presentation

- Recent intake of hallucinogens causing maladaptive behavior and psychological effects including depression or anxiety, ideas of reference, fear of becoming insane, prosecutory ideas, impaired judgment, impaired work or social functioning.
- Two or more of the following shortly after intake: 1) dilated pupils; 2) rapid heart rate; 3) sweating; 4) irregular heartbeat; 5) blurred vision; 6) poor coordination.

Specifiers, Codes and Comments

- Hallucinogen Dependence is part of the subgroup of Hallucinogen Use Disorders.
- Hallucinogen may consist of Phenylalkylamines and Indole Alkaloids
- Hallucinogen are also known as Bufotenin, Harmin, LSD, Psilocybin, DMT, Ibotenic Acid, Myristin, Oloaliqiu Mescaline, PCP, Psychodylyptic, Psycholytic, Psychotomimetic, Amanita Muscaria, Fly Agaric, Magic Mushroom, Morning Glory, Muscimol, Phencyclidine, Teonanactyl.
- From Latin – *intoxicare*, to poison, + *toxicum*, poison + *-ation*, indicating a process or condition.
- From Latin – *alucinari*, to wander in the mind + Greek – *genes*, born or produced.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Generalized Anxiety Disorder
Delirium
Hallucinogen Abuse
Hallucinogen Dependence
Hallucinogen Persisting Perception
Mood Disorder
Psychotic Disorder with Delusions
Psychotic Disorder with Hallucinations

Internet Resources

http://www.tpub.com/content/medical/14295/css/14295_232.htm
http://www.behavenet.com/capsules/disorders/hallucinogenintoxication.htm
http://www.emedicine.com/EMERG/topic223.htm
HALLUCINOGEN PERSISTING PERCEPTION

**Behavioral Presentation**

- Stops hallucinogenic intake suddenly after long term use.
- One or more of the following occurs after stopping use: 1) flashes of color; 2) trails of images; 3) afterimages; 4) halos; 5) sees things larger than they are; 6) sees things smaller than they are; 7) geometric hallucinations; 8) false peripheral perception of movement.

**Specifiers, Codes and Comments**

- Hallucinogen Dependence is part of the subgroup of Hallucinogen Use Disorders.
- Hallucinogen may consist of Phenylalkylamines and indole alkaloids
- Hallucinogen are also known as Bufotenin, Harmine, LSD, Psilocybin, DMT, Ibotenic Acid, Myristin, Ololiuqui Mescaline, PCP, Psychodyseptic, Psycholytic, Psychotomimetic, Amanita Muscaria, Fly Agaric, Magic Mushroom, Morning Glory, Muscimol, Phencyclidine, Teonanactyl.
- From Latin – *alucinari*, to wander in the mind + Greek – *genes*, born or produced

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested Warning:

  - Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Generalized Anxiety Disorder
- Delirium
- Hallucinogen Abuse
- Hallucinogen Dependence
- Hallucinogen Intoxication
- Mood Disorder
- Psychotic Disorder with Delusions
- Psychotic Disorder with Hallucinations

**Internet Resources**

- http://www.stormloader.com/hppd/
- http://ajp.psychiatryonline.org/cgi/content/full/155/10/1460

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HISTRIONIC PERSONALITY

Code Number: 301.50  Category: Personality

Behavioral Presentation

Five or more of the following: 1) uncomfortable when not the center of attention; 2) behavior in relationships is sexually seductive or provocative; 3) emotional expression shifts and is shallow; 4) uses physical appearance to become focus of attention; 5) speech lacking details and is vague; 6) very dramatic expression of emotion; 7) highly suggestible; 8) believes relationships are more intimate than is warranted.

Specifiers, Codes and Comments

Personality problems begin in early adult life.
Personality Disorders are grouped in clusters. Histrionic Personality is part of Cluster “B” disorders.
Studies suggest that approximately 2% to 3% of the general population may suffer from Histrionic Personality Disorder.
Studies suggest that approximately 10% to 15% of inpatients and outpatients may suffer from Histrionic Personality Disorder.
From Latin – histrionicus, like an actor, histrio, an actor.

Degree of Impairment  Suggested Course of Action  Psychopharmacology

Very Mild  Medical Attention
Mild  Therapy/Counseling
Moderate  Support Group
Moderate to Severe  Special Needs
Severe  Change of Location

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Antisocial Personality
Borderline Personality
Dependent Personality
Mood Disorder
Narcissistic Personality
Paranoid Personality
Schizotypal Personality

Internet Resources
http://www.mentalhealth.com/dis1/p21-pe06.html
http://www.pdc.co.il/hist.htm
http://www.toad.net/~arcturus/dd/histrion.htm
http://topcondition.com/images/mymindfield/histrionic_personality_disorder.htm
HYPOACTIVE SEXUAL DESIRE

**Code Number:** 302.71  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Fantasies about sexual activity are predominately void.
- Once engaged in genital sexual contact interest returns.
- Causes marked distress and interpersonal problems.

**Specifiers, Codes and Comments**
- *Lifelong Type* – existed for the individual’s entire sexual life.
- *Acquired Type* – exists for periods of time.
- *Generalized Type* – exists with any partner or sexual activity.
- *Situational Type* – exists only with certain partners or situations.
- *Due to Psychological Factors* – only psychological issues.
- *Due to Combined Factors* – both psychological and physical issues.

Hypoactive Sexual Desire Disorder is part of the Sexual Desire Disorders which are a subgroup of Sexual Dysfunctions.

*From Greek – hypo, under + Latin – activus, in a state of action; actus, a doing + ivus, tending.*

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

*Warning:* Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Female Orgasmic Disorder
- Female Separation Anxiety
- Major Depressive Disorder
- Obsessive-Compulsive Disorder
- Somatization Disorder
- Specific Phobia

**Internet Resources**
- [http://www.psychnet-uk.com/dsm_iv/hypoactivesexual_desire_disorder.htm](http://www.psychnet-uk.com/dsm_iv/hypoactivesexual_desire_disorder.htm)
- [http://www.sexhealth.org/problems/desire.shtml](http://www.sexhealth.org/problems/desire.shtml)
HYPOCHONDRIASIS

**Code Number:** 300.7  
**Category:** Somatoform

**Behavioral Presentation**
- Believes they are seriously ill for six months or longer.
- Is not part of a multiple pain group.
- Individual believes the physiological problems are real.

**Specifiers, Codes and Comments**
- *With Poor Insight.*
- From – Greek for, below the cartilage.

**Degree of Impairment**
- Very Mild
- Mild
- Moderate
- Severe

**Specifiers, Codes and Comments**
- Very Mild
- Mild
- Moderate
- Severe

**Degree of Impairment**
- Mild
- Moderate
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Body Dysmorphic Disorder  
Borderline Personality  
Conversion Disorder  
Delusional  
Factitious Disorder  
Generalized Anxiety Disorder  
Histrionic Personality  
Malingering  
Mood Disorder  
Obsessive-Compulsive Disorder  
Pain Disorder  
Panic Disorder  
Schizoid Personality  
Somatization Disorder  
Specific Phobia

**Internet Resources**

http://www.emedicine.com/MED/topic3122.htm  
http://ourworld.compuserve.com/homepages/malcolmi/chypo.htm  
http://www.calss.utoronto.ca/pamphlets/hypochondriasis.htm  
http://www.psychnet-uk.com/dsm_iv/hypochondriasis.htm
HYPMANIC EPISODE

**Code Number:** None

**Category:** Mood

**Behavioral Presentation**
- Four or more days, a mood that is elevated, expansive or elated above the individual’s typical non-depressed mood.
- Three or more of the following: 1) grandiose; 2) less need for sleep; 3) talkative; 4) racing thought; 5) distractable; 6) poor judgment; 7) increased psychomotor or increased goal-directed activity.
- Non-psychotic; delusions, hallucinations, bizarre behavior or speech.
- Less severe than a Manic Episode or Depressed Episode.

**Specifiers, Codes and Comments**

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<td>Therapy/Counseling Support Group</td>
<td>Natural Substance None Suggested</td>
</tr>
<tr>
<td>Mild to Moderate</td>
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<td></td>
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<tr>
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</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Attention-Deficit/Hyperactivity Disorder
Manic Episode

**Internet Resources**
http://www.mental-health-today.com/bp/hypo.htm
http://www.manicmoment.org/information/bad/the-hypomanic-episode.php
IDENTITY PROBLEM

Code Number: 313.82
Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Individual has problems with their identity: career, friendships, goals, morals, sexual orientation.

Specifiers, Codes and Comments

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | Medical Attention | Medications
Mild | Therapy/Counseling | Natural Substance
☒ Mild to Moderate | Support Group | None Suggested
Moderate | Special Needs | Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe | Change of Location |
Severe | Time off |

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.poeticspirit.com/identity.htm
http://www.psyassociates.com/
http://www.kagawa-jc.ac.jp/~steve_mc/jaltbsig/bilingual_identity.html
http://www.joensuu.fi/youth/abspsychology.htm
# INHALANT ABUSE

**Code Number:** 305.90  
**Category:** Substance-Related

## Behavioral Presentation

Over one twelve-month period inhalant intake causes clinical distress and impairment.

*One or more of the following* within a twelve-month period: 1) affects work, social, and leisure functioning; 2) continues to use inhalant in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using, and recovering from the effects of inhalant; 5) inhalant leads to legal problems; 6) continues use in despite knowing the effects on work, social and personal problems.

## Specifiers, Codes and Comments

- Inhalant Abuse is part of the subgroup of Inhalant Use Disorders.
- Inhalants are gasoline, glue, paint, and some aerosols, cleaning fluids, and other volatile substances.

## Degree of Impairment

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## Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

## Psychopharmacology

- Medications
- Natural Substance

### Warning:
Medications and natural substances should be used with a doctor’s approval.

## Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Generalized Anxiety Disorder
- Delirium
- Inhalant Dependence
- Inhalant Intoxication
- Mood Disorder
- Persisting Dementia
- Psychotic Disorders with Delusions
- Psychotic Disorders with Hallucinations

## Internet Resources

- [http://www.inhalant.org/](http://www.inhalant.org/)
- [http://www.aafp.org/afp/20030901/869.html](http://www.aafp.org/afp/20030901/869.html)
INHALANT DEPENDENCE

Code Number: 304.60

Category: Substance-Related

Behavioral Presentation

Over one twelve-month period inhalant intake causes clinical distress and impairment.

Three or more of the following within a twelve-month period: 1) more inhalant is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using and recovering from the effects of inhalant; 7) affects work, social, and leisure functioning; 8) continues to use a inhalant in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.

Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.

Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.

Sustained Partial Remission – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.

In a Controlled Environment – is in a controlled environment—hospital or inpatient clinic.

Inhalant Dependence is part of the subgroup of Inhalant Use Disorders.

Inhalants are gasoline, glue, paint, and some aerosols, cleaning fluids, and other volatile substances.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Delirium
Inhalants Abuse
Inhalants Intoxication
Mood Disorder
Persisting Dementia
Psychotic Disorders with Delusions
Psychotic Disorders with Hallucinations
Internet Resources
http://www.mentalhealth.com/dis/p20-sb06.html
http://www.med.umich.edu/1libr/aha/aha_inhaldep_bha.htm
http://www.annalsnyas.org/cgi/content/abstract/1025/1/481
http://www.fairview.org/healthlibrary/content/aha_inhaldep_bha.htm
INHALANT INTOXICATION

**Code Number:** 292.89

**Category:** Substance-Related

**Behavioral Presentation**

- Recent intentional intake of volatile inhalants or brief high-dose exposure causing maladaptive behavior and psychological effects including apathy, assaultiveness or belligerence, impaired judgment, and impaired work or social functioning.

  - *Two or more of the following:* 1) dizziness; 2) involuntary rhythmic eye movement; 3) poor coordination; 4) slurred speech; 5) unsteady walking; 6) lethargy; 7) diminished reflexes; 8) slowed psychomotor activity; 9) tremors; 10) general muscular weakness; 11) blurred or double vision; 12) stupor or coma; 13) euphoria.

**Specifiers, Codes and Comments**

- Inhalant Intoxication is part of the subgroup of Inhalant-Induced Disorders.
- Inhalants are gasoline, glue, paint, and some aerosols, cleaning fluids, and other volatile substances.
- From Latin – *intoxicare*, to poison, + *toxicum*, poison + *-ation*, indicating a process or condition.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- *Always rule out* General Medical Conditions
- *Always rule out* Substance Related Disorders

Generalized Anxiety Disorder
Delirium
Inhalants Abuse
Inhalants Dependence
Mood Disorder
Persisting Dementia
Psychotic Disorders with Delusions
Psychotic Disorders with Hallucinations

**Internet Resources**

- [http://gwbweb.wustl.edu/Users/cac/inhalant.htm](http://gwbweb.wustl.edu/Users/cac/inhalant.htm)
- [http://www.streetdrugs.org/inhalants.htm](http://www.streetdrugs.org/inhalants.htm)
INTERMITTENT EXPLOSIVE

Code Number: 312.34
Category: Impulse-Control

Behavioral Presentation
- On several occasions the individual loses control of behavior leading to aggression.
- Aggression leads to assault or destruction.
- Aggression is disproportionate to the situational psychological or social stressor.

Specifiers, Codes and Comments
- The individual exhibiting aggression has episodes that begin suddenly; individual lives on the edge with a hair-trigger temper. The aggression usually ends suddenly. They typically show remorse. Some may be sensitive to the intake of one or two alcoholic beverages. This is known as Pathological Intoxication.
- Intermittent Explosive Disorder may be referred to as Episodic Dyscontrol Syndrome or Explosive Personality.

Specifiers, Codes and Comments

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Antisocial Personality
Borderline Personality
Conduct Disorder
Panic Disorder
Major Depressive Disorder
Manic Episode
Oppositional Defiant Disorder
Schizoid Personality

Internet Resources
http://allpsych.com/disorders/impulse_control/explosivedisorder.html/
http://www.psychnet-uk.com/dsm_iv/intermittent_explosive_disorder.htm
http://www.ehendrick.org/healthy/001558.htm
http://www.mayhem.net/Crime/intermittent.html
KLEPTOMANIA

**Code Number:** 312.32  
**Category:** Impulse-Control

**Behavioral Presentation**
- Steals objects they do not need.
- Does not commit act out of anger or revenge.
- Is not a response to a delusion or hallucination.

**Specifiers, Codes and Comments**
- The individual has an ever increasing sense of tension and subsequently feels pleasure, gratification and relief after stealing.
- Behavior is believed to be ego-dystonic (the term was introduced by Sigmund Freud) meaning self-repugnant, alien, discordant, or inconsistent with the total personality of the Kleptomaniac.
- Studies suggest that approximately 1 in 20 shoplifters may receive the true diagnosis of Kleptomania.
- From Greek – *kleptein*, to steal + *mania*, madness.

**Degree of Impairment**
- Very Mild
- Mild
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Antisocial Personality
- Generalized Anxiety Disorder
- Bipolar I Disorder
- Bulimia Nervosa
- Conduct Disorder
- Dementia
- Dysthymic Disorder
- Generalized Anxiety Disorder
- Major Depressive Disorder
- Malingering
- Manic Episode
- Mood Disorder
- Schizoid Personality

**Internet Resources**
http://www.uihealthcare.com/topics/mentalemotionalhealth/ment3151.html
http://www.structurise.com/kleptomania/
MAJOR DEPRESSIVE EPISODE

Code Number: None    Category: Mood

Behavioral Presentation

Five or more of the following for at least two weeks for most of nearly every day (depressed mood or decreased interest in pleasure must be one of the five): 1) depressed; 2) problems with eating; 3) sleeping; 4) feelings of guilt; 4) loss of energy; 6) trouble concentrating; 7) suicidal thoughts.

Use codes for Major Depressive Episodes, Bipolar I Episodes, and Bipolar II Episodes.

Specifiers, Codes and Comments

- Mild – barely meets the criteria (Code – .x1).
- Moderate – between mild and severe (Code – .x2).
- Severe Without Psychotic Features – exceed minimum criteria (Code – .x3).
- Severe With Psychotic Features – delusions and hallucinations (Code – .x4).
- Severe With Mood Congruent Psychotic Features.
- Severe With Mood Incongruent Psychotic Features.
- With Catatonic Features.
- With Melancholic Features.
- With Atypical Features.
- With Postpartum Onset.
- In Partial Remission – now have fewer than five symptoms, or no symptoms for two months or less. (Code – .x5).
- In Full Remission – no symptoms for two months or more (Code – .x6).
- Unspecified (Code – .x0).
- Chronic – lasting two or more years.
- With Interepisode Recovery – periods of few symptoms.
- Without Interepisode Recovery – no periods of being symptom-free.
- With Seasonal Pattern – symptoms relate to the time of year.

Children and adolescents may appear irritable rather than depressed, and failure to gain weight instead of a weight loss.

Do not include symptoms caused by a General Medical Condition.

Do not use Major Depressive Disorder if it is on top of Dysthymic Disorder.

Internet Resources

http://www.psychnet-uk.com/dsm_iv/major_depression.htm
http://www.allaboutdepression.com/dia_03.html
http://www.mentalhealth.com/dis1/p21-md01.html
MAJOR DEPRESSIVE, SINGLE EPISODE

Code Number: 296.2x

Category: Mood

Behavioral Presentation

Individual has had one Major Depressive Episode depressed, problems with eating, sleeping, feelings of guilt, loss of energy, trouble concentrating; suicidal thoughts, need for more or less sleep.

There has been a Manic Episode, Mixed Episode, or Hypomanic Episode unless the episode was the result of a substance or General Medical Condition.

Specifiers, Codes and Comments

See Major Depressive Episode for coding “x” types.

Major Depressive Disorder, Single Episode is part of a subgroup of Depressive Disorder.

Studies suggest that the lifetime risk is approximately 10% to 25% of women and 5% to 12% of men may suffer from Major Depressive Disorder Disorders.

Studies suggest that approximately 50% of those who have a single episode will have another episode.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

➡️ Medical Attention
➡️ Therapy/Counseling
➡️ Support Group
➡️ Special Needs
➡️ Change of Location
➡️ Time off

Psychopharmacology

➡️ Medications
➡️ Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Attention-Deficit/Hyperactivity
Bereavement
Delusional Disorder
Hypomanic Episode
Major Depressive Disorder, Recurrent
Manic Episode
Mixed Episode
Psychotic Disorder
Schizoaffective Disorder
Schizophrenia
Schizophreniform

Internet Resources
http://www.allaboutdepression.com/dia_03.html
http://counsellingresource.com/distress/mood-disorders/depression-symptoms.html
http://www.psychologyinfo.com/depression/major.htm
http://www.a-silver-lining.org/BPNDepth/criteria_d.html
MAJOR DEPRESSIVE, RECURRENT

Code Number: 296.3x

Category: Mood

Behavioral Presentation

Individual has had two or more Major Depressive Episode (Pg. 200), depressed, problems with eating, sleeping, feelings of guilt, loss of energy, trouble concentrating; suicidal thoughts, need for more or less sleep.

There has never been a Manic Episode, Mixed Episode or Hypomanic Episode unless the episode was the result of a substance or General Medical Condition.

Specifiers, Codes and Comments

See Major Depressive Episode for coding “x” types.

Major Depressive Disorder, Recurrent is part of a subgroup of Depressive Disorder.

A two-month period must elapse between episode where Major Depressive Episodes have not occurred.

Studies suggest that the lifetime risk is approximately 10% to 25% of women and 5% to 12% of men may suffer from Major Depressive Disorder Disorders.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Attention-Deficit/Hyperactivity Disorder
Bereavement
Delusional Disorder
Hypomamic Episode
Major Depressive Disorder, Single Episode
Manic Episode, Mixed Episode
Psychotic Disorder
Schizoaffective Disorder
Schizophrenia
Schizophreniform.

Internet Resources

http://www.behavenet.com/capsules/disorders/mjrdepdrepisode.htm
http://www.healthyplace.com/communities/depression/major_depression.asp
http://www.mentalhealth.com/icd/p22-md01.html
http://depressiongenetics.med.upenn.edu/Depression/depressionstudy.htm
MALE ERECTILE

**Code Number:** 302.72  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Unable to maintain an erection sufficient enough to engage in intercourse.
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

**Specifiers, Codes and Comments**
- *Lifelong Type* – existed for the individual’s entire sexual life.
- *Acquired Type* – exists for periods of time.
- *Generalized Type* – exists with any partner or sexual activity.
- *Situational Type* – exists only with certain partners or situations.
- *Due to Psychological Factors* – only psychological issues.
- *Due to Combined Factors* – both psychological and physical issues.

Male Erectile Disorder is part of the Sexual Arousal Disorders which are a subgroup of Sexual Dysfunctions.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

**Internet Resources**
- [http://bmj.bmjournals.com/cgi/content/full/316/7132/678](http://bmj.bmjournals.com/cgi/content/full/316/7132/678)  
- [http://www.healthatoz.com/healthatoz/Atoz/de/caz/repr/sexi/sperectile.jsp](http://www.healthatoz.com/healthatoz/Atoz/de/caz/repr/sexi/sperectile.jsp)  
- [http://www.psychnet-uk.com/dsm_iv/male_erectile_disorder.htm](http://www.psychnet-uk.com/dsm_iv/male_erectile_disorder.htm)  
- [http://www.hisandherhealth.com/articles/What_is_Male_Erectile_Dysfunction_or_Impotence.shtml](http://www.hisandherhealth.com/articles/What_is_Male_Erectile_Dysfunction_or_Impotence.shtml)

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MALE ORGASMIC
Behavioral Presentation

- Adequate sexual excitement does not bring about an orgasm.
- Lack of orgasm is persistent and repeated in terms of being delayed or absent.
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

Specifiers, Codes and Comments

- **Lifelong Type** – existed for the individual’s entire sexual life.
- **Acquired Type** – exists for periods of time.
- **Generalized Type** – exists with any partner or sexual activity.
- **Situational Type** – exists only with certain partners or situations.
- **Due to Psychological Factors** – only psychological issues.
- **Due to Combined Factors** – both psychological and physical issues.

Male Orgasmic Disorder is part of the Orgasmic Disorders which are a subgroup of Sexual Dysfunctions.

Male Orgasmic Disorder was formerly referred to as Inhibited Male Orgasm, Orgasmic Impotence, Ejaculatory Impotence, or Impotence.

Degree of Impairment

- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

Suggested Course of Action

- **Medical Attention**
- **Therapy/Counseling**
- **Support Group**
- **Special Needs**
- **Change of Location**
- **Time off**

Psychopharmacology

- **Medications**
- **Natural Substance**
- **None Suggested**

**Warning**: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

- **Always rule out General Medical Conditions**
- **Always rule out Substance Related Disorders**

Internet Resources

- [http://www.news-medical.net/?id=1341](http://www.news-medical.net/?id=1341)
- [http://www.hopkins-menshealth.org/disease_article.php3?id=60](http://www.hopkins-menshealth.org/disease_article.php3?id=60)
MALINGERING

Code Number: V65.2

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
The individual intentionally feigns being sick, mentally or physically, for the purpose of obtaining some sort of gain such as money, drugs, insurance settlement, or avoiding punishment, work, jury duty, military service.

Specifiers, Codes and Comments

<table>
<thead>
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<td>Mild to Moderate</td>
<td>Support Group</td>
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<td>Moderate</td>
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<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
<td></td>
</tr>
</tbody>
</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.psychnet-uk.com/dsm_iv/malingering.htm
http://ourworld.compuserve.com/homepages/Marc_Feldman_2/
http://cms.psychologytoday.com/conditions/malingering.html
MANIC EPISODE

**Code Number:** None

**Category:** Mood

**Behavioral Presentation**

- For a week or more (less if hospitalized) individual is elated; may be irritable, or expansive.
- *Three or more of the following:* 1) grandiose; 2) talkative; 3) hyperactive; 4) distractible; 5) racing thoughts; 6) reduced need for sleep; 7) bad judgment.
- *One or more of the following:* 1) psychotic features; 2) hospitalization; 3) impairs work, social, or personal functioning.

**Specifiers, Codes and Comments**

- *Mild* – barely meet the criteria (Code – .x1).
- *Moderate* – between mild and severe (Code – .x2).
- *Severe Without Psychotic Features* – exceed minimum criteria (Code – .x3).
- *Severe With Psychotic Features* – delusions and hallucinations (Code – .x4).
- *Severe With Mood Congruent Psychotic Features.*
- *Severe With Mood Incongruent Psychotic*
  *With Catatonic Features.*
  *With Melancholic Features.*
  *With Atypical Features.*
  *With Postpartum Onset.*
- *In Partial Remission* – now have fewer than five symptoms, or no symptoms for two months or less. (Code – .x5).
- *In Full Remission* – no symptoms for two months or more (Code – .x6).
- *Unspecified* (Code – .x0).
- *Chronic* – lasting two or more years.
- *With Interepisode Recovery* – periods of few symptoms.
- *Without Interepisode Recovery* – no periods of being symptom-free.
- *With Seasonal Pattern* – symptoms relate to the time of year.

**Internet Resources**

- [http://www.a-silver-lining.org/BPNDepth/criteria_d.html#BP1D_MREManic](http://www.a-silver-lining.org/BPNDepth/criteria_d.html#BP1D_MREManic)
MATHEMATICS

Code Number: 315.1

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Mathematical ability is markedly less than expected given the individual’s age, intelligence and education.

The mathematical problem impedes academic achievement and daily living.

Specifiers, Codes and Comments

Mathematics Disorder is part of a subgroup of Learning Disorders.

Learning Disorders were formerly known as Academic Skills Disorders.

Code all sensory deficits or General Medical Conditions on Axis III.

Studies suggest that approximately 1% of all public school students may suffer from Mathematics Disorder.

Studies suggest that approximately 5% of all public school students may suffer from Learning Disorders.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Communication Disorder
Mental Retardation
Pervasive Development Disorder
Pyromania

Internet Resources

http://www.athealth.com/Consumer/disorders/Math.html
http://www.nichd.nih.gov/crmc/cdb/math.htm
http://www.notmykid.org/parentArticles/LearningDisorders/default.asp
**MEDICATION-INDUCED POSTURAL TREMOR**

**Code Number:** 333.1  
**Category:** *Other Conditions That May Be a Focus of Clinical Attention*

**Behavioral Presentation**
Antidepressants, lithium or valproate may induce a fine tremor.

**Specifiers, Codes and Comments**
Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

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<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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<tbody>
<tr>
<td>Very Mild</td>
<td>✔ Medical Attention</td>
<td>✔ Medications</td>
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<tr>
<td>Mild</td>
<td>Therapy/Counseling</td>
<td>Natural Substance</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
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<td>Moderate to Severe</td>
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</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
<td></td>
</tr>
</tbody>
</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Anxiety Disorder  
Schizoid Personality  
Somatoform Disorder  
Substance-Related  
Tic Disorder

**Internet Resources**
http://www.mentalhealth.com/help/p10-dis2.html  
http://www.parkinson.org/site/pp.asp?c=9dJFJLPwB&b=71354&printmode=1  
http://www.parkinsons.northwestern.edu/parkinson_questions.html  
http://baywood.metapress.com/app/home/contribution.asp?wasp=g3tlrmturj3vme2jqjft&referrer=parent&backto=issue,8,8;journal,11,131;linkingpublicationresults,1:300314,1
MENTAL RETARDATION

Code Number: None

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- Intellectual functioning is below an average Intelligence Quotient (IQ) of 70.
- Two or more of the following are below what would be expected for the person’s age:
  1) communication; 2) caring for self; 3) safety; 4) working; 5) relating to others; 6) living at home;
  7) health; 8) using free time; 9) academic functioning; 10) directing self; 11) using community resources.
- More trouble functioning than would be expected for the age or culture.
- Begins before age 18.

Specifiers, Codes and Comments
- Mild Mental Retardation (IQ 50 – 55 to 70) (Code – 317).
- Moderate Mental Retardation (IQ 35 – 40 to 50 – 55) (Code – 318.0).
- Severe Mental Retardation (IQ 20 – 25 to 35 – 40) (Code – 318.1).
- Profound Mental Retardation (IQ less then 20 – 25) (Code – 318.2).
- Mental Retardation, Severity Unspecified (Code – 319).
- The Intelligence Quotient (IQ) can be identified through the administration of several standardized tests: Wechsler Intelligence Scales for Children, 3rd Edition, Stanford-Binet, 4th Edition or Kaufman Assessment Battery for Children. For Mental Retardation, Severity Unspecified individual can not be tested.
- Studies suggest that approximately 1% of the general population may suffer from varying degrees of Mental Retardation.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Asperger’s
Autism
Borderline Intellectual Functioning
Communication Disorder
Dementia
Learning Disorder
Pervasive Developmental Disorder
Rett’s
Internet Resources
http://www.nichcy.org/pubs/factshe/fs8txt.htm
http://www.aacap.org/publications/factsfam/retarded.htm
http://mass.gov/portal/index.jsp?pageID=eohhs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Mental+Retardation&sid=Eeohhs2
MIXED EPISODE, MOOD

Code Number: None

Category: Mood

Behavioral Presentation

For two weeks, nearly every day has fulfilled criteria for both Major Depressive Episode: depressed, problems with eating, sleeping, feelings of guilty, loss of energy, trouble concentrating, suicidal thoughts and Manic Episode elated, may be irritable, grandiose talkative, hyperactive, distractible, less need for sleep, bad judgment; spends money; overly sexual.

One or more of the following: 1) psychotic features; 2) hospitalization; 3) impairs work, social or personal functioning.

Specifiers, Codes and Comments

Mild – barely meet the criteria (Code – .x1).
Moderate – between mild and severe (Code – .x2).
Severe Without Psychotic Features – exceed minimum criteria (Code – .x3).
Severe With Psychotic Features – delusions and hallucinations (Code – .x4).
Severe With Mood – Congruent Psychotic Features.
Severe With Mood – Incongruent Psychotic Features.
With Catatonic Features.
With Melancholic Features.
With Atypical Features.

In Partial Remission – now have fewer than five symptoms or no symptoms for two months or less (Code – .x5).
In Full Remission – no symptoms for two months or more (Code–.x6)
With Catatonic Features.
With Melancholic Features.
With Atypical Features.

With Postpartum Onset.
Unspecified (Code – .x0).
Chronic – lasting two or more years.
With Interepisode Recovery – periods of few symptoms.
Without Interepisode Recovery – no periods of being symptom-free.
With Seasonal Pattern – symptoms relate to the time of year.

Internet Resources

http://www.psychnet-uk.com/dsm_iv/dysthymic_cyclothymic_episodes.htm
http://www.medical-library.org/journals2a/bipolar_1_disorder.htm
MIXED RECEPTIVE-EXPRESSIVE LANGUAGE

**Code Number:** 315.32

**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**

- Expressive and receptive language development are lower than nonverbal intellectual capacity.
- Problems understanding sentences, words, specific classes of words, i.e., spatial terms.
- May have materially limited vocabulary, make errors of tense, poor word recall or create shorter or less complex sentences than is developmentally expected.
- Education, occupational achievement or social communication is interrupted.

**Specifiers, Codes and Comments**

- Mixed Receptive-Expressive Language Disorder is part of a subgroup of Communication Disorders.
- Mental retardation, environmental deprivation, speech-motor or sensory deficit may worsen the individual’s problem.
- Developmental language delays are more common than acquired language delays.
- Code on Axis III if there is a sensory deficit or General Medical Condition.
- Mental retardation, environmental deprivation or speech-motor or sensory deficit may worsen the problem.
- Studies suggest that approximately 3% of school age children and 5% of preschool children may suffer from Mixed Receptive-Expressive Language Disorder.

<table>
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<td>Very Mild</td>
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<td>Mild</td>
<td>Therapy/Counseling</td>
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</tr>
<tr>
<td>☑ Mild to Moderate</td>
<td>Support Group</td>
<td>☑ None Suggested</td>
</tr>
<tr>
<td>Moderate</td>
<td>☑ Special Needs</td>
<td><strong>Warning:</strong> Medications and natural substances should be used with a doctor’s approval.</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
<td></td>
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<tr>
<td>Severe</td>
<td>Time off</td>
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</tbody>
</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Pervasive Developmental Disorder
Autistic
Mental Retardation
Disorder of Written Expression
Selective Mutism

**Internet Resources**

- [http://www.drkoop.com/ency/article/001545.htm](http://www.drkoop.com/ency/article/001545.htm)
- [http://www.healthcentral.com/mhc/top/001545.cfm](http://www.healthcentral.com/mhc/top/001545.cfm)
- [http://www.shands.org/health/information/article/001545.htm](http://www.shands.org/health/information/article/001545.htm)
- [http://www.umm.edu/ency/article/001545.htm](http://www.umm.edu/ency/article/001545.htm)
NARCISSISTIC PERSONALITY

Code Number: 301.81  
Category: Personality

Behavioral Presentation

Five or more of the following: 1) grandiose: exaggerates their ability and accomplishments; 2) dwells on fantasies of beauty, success, power, brilliance, ideal love; 3) believes they should be with institutions or those of great status; 4) need for being overly admired; 5) expects treatment that is more than one would expect; 6) exploits others; 7) no empathy for others; 8) envies others or assumes others envy them; 9) haughty, arrogant attitude or behavior.

Specifiers, Codes and Comments

Personality problems begin in early adult life. Personality Disorders are grouped in clusters. Narcissistic Personality is part of Cluster “B” disorders. Studies suggest that approximately 2% to 16% of the psychiatric population and 1% are less in the general population may suffer from Narcissistic Personality Disorder.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Antisocial Personality
Borderline Personality
Dependent Personality
Histrionic Personality
Hypomanic Episode
Manic Episode
Obsessive-Compulsive Disorder
Paranoid Personality
Schizotypal Personality

Internet Resources

http://www.mentalhealth.com/dis/p20-pe07.html
http://groups.msn.com/NARCISSISTICPERSONALITYDISORDER
http://www.healthyplace.com/communities/personality_disorders/narcissism/
http://www.mentalhealth.com/dis1/p21-pe07.html
NARCOLEPSY

Code Number: 347

Category: Sleep

Behavioral Presentation

- Each day for three months or more, the individual has attacks of sudden, irresistible sleep.
- Either/or Cataplexy (Pg. 450), Hypnagogic (Pg. 450), or Hypnopomnic (Pg. 450), Hallucinations (Pg. 450), or sleep paralysis at the beginning or end of sleep.

Specifiers, Codes and Comments

- Narcolepsy is part of a subgroup of Dyssomnias.
- Narcolepsy is also called Disorder of Excessive Somnolence
- Studies suggest that 0.02% to 0.16% of the adult population may suffer from Narcolepsy.
- Dysnomnias, from Greek – dys, bad or abnormal + somnus, sleep.

Degree of Impairment

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<tr>
<td>Severe</td>
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</tr>
</tbody>
</table>

Psychopharmacology

- ☑ Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Breathing-Related Sleep Disorder
Generalized Primary Hypersomnia
Hypersomnia Related to Another Medical Condition
Major Depressive Episode

Internet Resources

http://www.ninds.nih.gov/disorders/narcolepsy/narcolepsy.htm
http://www.narcolepsy.org.uk/
http://expage.com/page/livingwithnarcolepsy
http://www.sleepdisorderchannel.net/narcolepsy/
NEGLECT OF CHILD

Code Number: V61.21

Category: Other Conditions That May Be a focus of Clinical Attention

Behavioral Presentation

Problems relating to the child neglect and abandonment.

Specifiers, Codes and Comments

If the clinical attention is focused on the victim use the following (Code – 995.52)

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</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources

http://www.focusas.com/Abuse.html
http://www.nursingceu.com/NCEU/courses/childabuse/
http://www.casanet.org/library/abuse/munchausen.htm
NEUROLEPTIC-MALIGNANT SYNDROME

**Code Number:** 333.92  
**Category:** Other Conditions That May Be a Focus of Clinical Attention

### Behavioral Presentation
Medication leads to muscle rigidity, fever, problems of sweating, trouble swallowing, incontinence, and Delirium.

### Specifiers, Codes and Comments
Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

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### Alternate Diagnostic Presentation

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Generalized Anxiety Disorder
- Schizoid Personality
- Somatoform Disorder
- Substance-Related
- Tic Disorder

### Internet Resources
- [http://www.nmsis.org/](http://www.nmsis.org/)
- [http://www.cmdg.org/Movement_/drug/Neuroleptic_Malignant_Syndrome/neuroleptic_malignant_syndrome.htm](http://www.cmdg.org/Movement_/drug/Neuroleptic_Malignant_Syndrome/neuroleptic_malignant_syndrome.htm)
NEUROLEPTIC-INDUCED ACUTE AKATHISIA

**Code Number:** 333.99  
**Category:** *Other Conditions That May Be a Focus of Clinical Attention*

**Behavioral Presentation**
After beginning intake of the medication individuals may become acutely restless and unable to remain seated.

**Specifiers, Codes and Comments**
Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
  - None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Generalized Anxiety Disorder  
Schizoid Personality  
Somatoform Disorder  
Substance-Related  
Tic Disorder

**Internet Resources**
http://www.cochrane.org/cochrane/revabstr/AB003727.htm  
http://209.211.250.105/cochrane/revabstr/ab001946.htm  
http://bjp.rcpsych.org/cgi/content/full/179/1/4  
NEUROLEPTIC-INDUCED ACUTE DYSTONIA

Code Number: 333.7

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Medication may cause contracting muscles of the head, neck and other parts of the body.

Specifiers, Codes and Comments
Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

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Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Schizoid Personality
Somatoform Disorder
Substance-Related
Tic Disorder

Internet Resources
http://ajp.psychiatryonline.org/cgi/content/abstract/145/8/993
http://www.behavenet.com/capsules/disorders/niacutedystonia.htm
http://www.emedicine.com/med/topic2614.htm
http://www.pni.org/books/innovative/abstract_ch6.html
NEUROLEPTIC-INDUCED PARKINSONISM

**Code Number:** 332.1  
**Category:** Other Conditions That May Be a Focus of Clinical Attention

### Behavioral Presentation
Medication may induce frozen face, shuffling gait and pill-rolling tremor.

### Specifiers, Codes and Comments
Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

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### Alternate Diagnostic Presentation

- *Always rule out* General Medical Conditions  
- *Always rule out* Substance Related Disorders

Generalized Anxiety Disorder  
Schizoid Personality  
Somatoform Disorder  
Substance-Related  
Tic Disorder

### Internet Resources
- [http://archderm.ama-assn.org/cgi/content/abstract/119/6/473](http://archderm.ama-assn.org/cgi/content/abstract/119/6/473)  
- [http://ajp.psychiatryonline.org/cgi/content/abstract/133/8/940](http://ajp.psychiatryonline.org/cgi/content/abstract/133/8/940)  
- [http://www.priory.com/psych/frames/introd.htm](http://www.priory.com/psych/frames/introd.htm)  
- [http://www.medicine.mcgill.ca/psychiatry/desp-ab.htm](http://www.medicine.mcgill.ca/psychiatry/desp-ab.htm)
NEUROLEPTIC-INDUCED TARDIVE DysKINESIA

**Code Number:** 333.82

**Category:** Other Conditions That May Be a Focus of Clinical Attention

**Behavioral Presentation**

A few months or more after intake of medication, temporary or permanent movements of the face, jaw, tongue, or limbs may begin.

**Specifiers, Codes and Comments**

Medication-Induced Movement Disorders may be important because of being mistaken for Anxiety Disorders, Schizoid Personality, Somatic Disorders, Substance-Related Disorders, Tic, etc., therefore, the management of patients receiving psychopharmaceuticals may be difficult.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Schizoid Personality
Somatoform Disorder
Substance-Related
Tic Disorder

**Internet Resources**

http://ajp.psychiatryonline.org/cgi/content/abstract/133/8/940
http://www.priory.com/psych/frames/introd.htm
http://neuro.psychiatryonline.org/cgi/content/abstract/9/4/562
NICOTINE DEPENDENCE

**Code Number:** 305.1  
**Category:** Substance-Related

**Behavioral Presentation**

Over one twelve-month period, nicotine intake causes clinical distress and impairment.  
*Three or more of the following* within a twelve-month period: 1) more nicotine is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using, and recovering from the effects of nicotine; 7) affects work, social, and leisure functioning; 8) continues to use a nicotine in spite of its negative physical and psychological effects.

**Specifiers, Codes and Comments**

- With Physiological Dependence – evidence of tolerance or withdrawal.
- Without Physiological Dependence – no evidence of tolerance or withdrawal.
- Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
- Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
- Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.
- Sustained Partial Remission – for twelve months or longer does not meet criteria FOR Dependence, but one or more of the criteria for Abuse and Dependence have been met.

Dependence is part of the subgroup of Nicotine Use Disorders.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

**Nicotine Withdrawal**

**Internet Resources**

- [http://www.mayoclinic.com/invoke.cfm?id=DS00307](http://www.mayoclinic.com/invoke.cfm?id=DS00307)
- [http://mayoresearch.mayo.edu/mayo/research/nicotine_research_center/](http://mayoresearch.mayo.edu/mayo/research/nicotine_research_center/)
NICOTINE WITHDRAWAL

Code Number: 292.0

Category: Substance-Related

Behavioral Presentation

- Has used nicotine on a daily basis for several weeks or more.
- Four or more of the following 24 hours after discontinuing use experiences: 1) Dysphoria or Depression; 2) Insomnia; 3) frustration, anger, or irritability; 4) anxiety; 5) difficulty concentrating; 6) restless; 7) slower heart rate; 8) appetite increase.

Specifiers, Codes and Comments

Nicotine Withdrawal is part of the subgroup of Nicotine-Induced Disorders.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Nicotine Dependence.

Internet Resources

http://whyquit.com/whyquit/A_Symptoms.html
http://www.quit-smoking.net/nws.html
http://www.umm.edu/ency/article/000953.htm
NIGHTMARE

Code Number: 307.47  Cat: Sleep

Behavioral Presentation

- Upon awakening remembers frightening dreams concerning threats of security, self-esteem, survival, death.
- Immediately becomes alert upon awakening.

Specifiers, Codes and Comments

- Nightmare Disorder is part of a subgroup of Parasomnias.
- Nightmare Disorder was formerly known as Dream Anxiety Disorder.
- Frightening dreams usually happen during the second half of sleeping or napping.
- Studies suggest that approximately 10% to 50% of children ages 3 to 5 have nightmares.
- Studies suggest that approximately 50% of adults may occasionally have nightmares.
- Studies suggest that approximately 3% of young adults may have frequent or constant nightmares.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
  - Moderate
  - Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Breathing-Related Sleep Disorder
Narcolepsy
Panic Attacks
Sleep Terror Disorder

Internet Resources

http://psychcentral.com/disorders/sx48.htm
http://cms.psychologytoday.com/conditions/nightmare.html
http://www.psychnet-uk.com/dsm_iv/nightmare_disorder.htm
http://www.macalester.edu/~psych/whathap/UBNR/nightmares/zNightmare_Disorder.html
NONCOMPLIANCE WITH TREATMENT

Code Number: V15.81

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
The individual refuses or ignores treatment intervention such as therapy, medication or medical treatment.

Specifiers, Codes and Comments

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Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.mhsourc.html.com/expert/exp1032601a.html
http://www.drada.org/ReferenceShelf/goldstein.html
http://www.healthcentral.com/mhc/top/000935.cfm
http://www.primalworks.com/thoughts/thought020408.html
## OBSESSIVE-COMPULSIVE

**Code Number:** 300.3  
**Category:** Anxiety

### Behavioral Presentation
- **Obsessions** – persistent thoughts, impulses or images causing distress. Worries, tries to disregard thoughts and feelings, knows they are unreasonable and that the obsessions are in their own mind.
- **Compulsions** – repeats physical or mental behaviors in response to obsessions or strict rules. Practices behavior to decrease, avoid or eliminate distress that is unrealistic or excessive in relation to the events.
- Obsessions or Compulsions cause severe distress, take up time, interfere with social, work or personal functioning.

### Specifiers, Codes and Comments
- **With Poor Insight** – does not know the obsession or compulsion is unreasonable.
- **Obsessions Only**
- **Compulsions Only**
- Primary fears: contamination – hand, body washing, cleaning; doubts – “Did I close the garage door?”
- Obsessional Neurosis is another name for Obsessive-Compulsive Disorder.
- Studies suggest that approximately 0.5% to 2.1% of adults may suffer from Obsessive-Compulsive Disorder with an approximately 2.5% lifetime prevalence.
- From Latin – *obsessus*, besieged; from *ob*, in front + *sidere*, to sit + *compulsare* to compel frequently or habitually; from *compellere*, to compel.

### Degree of Impairment

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### Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Antisocial Personality  
Body Dysmorphic Disorder  
Delusional Disorder  
Eating Disorder Disorder  
Generalized Anxiety Disorder  
Hypochondriasis  
Major Depressive Disorder  
Narcissistic Personality  
Obsessive-Compulsive Personality
Psychotic Disorder
Schizoid Personality
Schizophrenia
Social Phobia
Trichotillomania
Specific Phobia
Stereotypic Movement Disorder
Tic Disorder

Internet Resources
http://www.ocfoundation.org/
http://mentalhelp.net/poc/center_index.php?id=6
http://psychcentral.com/ocdquiz.htm
OBSESSIVE-COMPULSIVE PERSONALITY

Code Number: 301.4

Category: Personality

Behavioral Presentation

*Four or more of the following:* 1) absorbed with schedules, details, rules, organization, order, lists; 2) perfectionism interferes with completing tasks; 3) leisure is overrun with work; 4) overly diligent about morals, ethics, values; inflexible; 5) hoards useless items; 6) others must do things their way before they will delegate tasks; 7) hoards money, is stingy; 8) stubborn, rigid.

Specifiers, Codes and Comments

- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Obsessive-Compulsive Personality is part of Cluster “C” disorders.
- The absence of true obsessions or compulsions should be distinguished from Obsessive-Compulsive Disorder.
- Studies suggest that approximately 1% of the general population and 3% to 10% of those in the psychiatric facilities may suffer from Obsessive-Compulsive Personality Disorder.
- Obsessive-Compulsive Personality Disorder is also referred to as Anankastic Personality Disorder.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

- Antisocial Personality
- Obsessive-Compulsive
- Narcissistic Personality
- Schizoid Personality

Internet Resources

http://www.mentalhealth.com/dis/p20-pe10.html
http://www.toad.net/~arcturus/dd/ocpd.htm
http://www.geocities.com/ptypes/obsessive-compd.html
OCCUPATIONAL PROBLEM

Behavioral Presentation
Individual has problems with work including selecting a career and job dissatisfaction.

Specifiers, Codes and Comments

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Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.missionarycare.com/reentry6.htm
http://www.brooks.af.mil/web/consult_service/waiver%20guide/Psychiatry/VCodes.htm
ONYCHOTILLOMANIA

**Code Number:** 312.30

**Category:** *Impulse-Control* (Pg. 366)

**Behavioral Presentation**
Biting or picking nails or skin from fingers and sometimes toes.

**Specifiers, Codes and Comments**
- The individual feels tension and emotion. Once the need to bite and pick has been fulfilled the individual feels pleasure, gratification and relief.
- Onychotillomania is so common that it not specifically mentioned in the DSM. Rather, it is considered, Not Otherwise Specified as a category.

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**Alternate Diagnostic Presentation**

Always rule out **General Medical Conditions**

Always rule out **Substance Related Disorders**

Generalized Anxiety Disorder
Mood Disorder
Obsessive-Compulsive Disorder
Pica Disorder
Stereotypic Movement Disorder

**Internet Resources**
http://www.findarticles.com/p/articles/mi_m3225/is_n6_v55/ai_19464388
http://content.karger.com/ProdukteDB/produkte.asp?Aktion=ShowPDF&Produkt
OPIOID ABUSE

Code Number: 305.00
Category: Substance-Related

Behavioral Presentation
Over one twelve-month period opioid intake causes clinical distress and impairment.
One or more of the following within a twelve-month period: 1) affects work, social and leisure functioning; 2) continues to use opioid in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using and recovering from the effects of opioid; 5) opioid abuse leads to legal problems; 6) continues use in spite knowing the effects on work, social and personal problems

Specifiers, Codes and Comments
Opioid Abuse is part of the subgroup of Opioid Use Disorders.
Opioids consist of substances such as Morphine, Heroin, Codeine, Methadone, and Meperidine.

Degree of Impairment
Very Mild
Mild
Mild to Moderate
Moderate
Severe

Suggested Course of Action
Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology
Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation
Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Opioid Dependence
Opioid Intoxication
Opioid Intoxication Delirium
Opioid Withdrawal
Opioid-Induced Mood Disorder
Opioid-Induced Psychotic Disorder with Delusions
Opioid-Induced Psychotic Disorder with Hallucinations
Opioid-Induced Sexual Dysfunction
Opioid-Induced Sleep Disorder

Internet Resources
http://www.emedicine.com/med/topic1673.htm
http://www.fpnotebook.com/PSY41.htm
http://www.google.com/search?hl=en&lr=&q=%EF%BB%BFopioid+Abuse&btnG=Search
http://www.ndri.org/ctrs/itsr/otp.html
OPIOID DEPENDENCE

Code Number: 304.00  
Category: Substance-Related

Behavioral Presentation
Over one twelve-month period opioid intake causes clinical distress and impairment. *Three or more of the following* within a twelve-month period: 1) more opioid is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for, using and recovering from the effects of opioid; 7) effects work, social, and leisure functioning; 8) continues to use an opioid in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments
- **With Physiological Dependence** – evidence of tolerance or withdrawal.
- **Without Physiological Dependence** – no evidence of tolerance or withdrawal.
- **Early Full Remission** – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
- **Early Partial Remission** – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
- **Sustained Full Remission** – for twelve months or longer does not meet criteria for Abuse or Dependence.
- **Sustained Partial Remission** – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.
- **On Agonist Therapy** – on prescribed agonist medication, i.e., methadone.
- **In a Controlled Environment** – is in a controlled environment–hospital or inpatient clinic.

Opioid Dependence is part of the subgroup of Opioid Use Disorders.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Opioid Abuse
Opioid Intoxication
Opioid Intoxication Delirium
Opioid Withdrawal
Opioid-Induced Mood Disorder
Opioid-Induced Psychotic Disorder With Delusions
Opioid-Induced Psychotic Disorder With Hallucinations
Opioid-Induced Sexual Dysfunction
Opioid-Induced Sleep Disorder

Internet Resources
http://www.aatod.org/
http://www.mentalhealth.com/dis/p20-sb08.html
http://www.suboxone.com/Suboxone/patients/understd.htm

OPIOID INTOXICATION

Code Number: 292.89

Category: Substance-Related

Behavioral Presentation
- Recent intake of opioid causing maladaptive behavior and psychological effects including euphoria leading to apathy, depression, or anxiety, speeded up or slowed psychomotor activity, impaired judgment, and impaired work, and social functioning.
- *One or more of the following:* 1) slurred speech; 2) impaired attention or memory; 3) sleepiness or coma.

Specifiers, Codes and Comments
- *With Perceptual Disturbances* – auditory, visual illusions; tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).
- Opioid Intoxication is part of the subgroup of Opioid-Induced Disorders.
- Opioids consist substances such as Morphine, Heroin, Codeine, Methadone, and Meperidine.
- From Latin – *intoxicare*, to poison, + *toxicum*, poison + *-ation*, indicating a process or condition.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Opioid Abuse
Opioid Dependence
Opioid Intoxication Delirium
Opioid Withdrawal
Opioid-Induced Mood Disorder
Opioid-Induced Psychotic Disorder With Delusions
Opioid-Induced Psychotic Disorder With Hallucinations
Opioid-Induced Sexual Dysfunction
Opioid-Induced Sleep Disorder

Internet Resources
http://www.drkoop.com/ency/article/000948.htm
http://www.umm.edu/ency/article/000948.htm
http://www.ehendrick.org/healthy/000948.htm
**OPIOID WITHDRAWAL**

**Code Number:** 292.0  
**Category:** Substance-Related

**Behavioral Presentation**

- Stops or reduces opioid intake suddenly after heavy use for at least several weeks or been given contrary medication after extended use. Affects work, social leisure functioning.
- *Three or more of the following* within minutes to several days: 1) mood swings; 2) aching muscles; 3) tearing or runny nose; 4) sleeplessness; 5) nausea or vomiting; 6) dilated pupils, piloerection, or sweating; 7) diarrhea; 8) yawing; 9) fever.

**Additional Notations and Specifiers, Codes and Comments**

Opioid Withdrawal is part of the subgroup of Opioid-Induced Disorders.

Opioids consist of substances such as Morphine, Heroin, Codeine, Methadone, and Meperidine.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Opioid Abuse  
- Opioid Dependence  
- Opioid Intoxication  
- Opioid Intoxication Delirium  
- Opioid-Induced Mood Disorder  
- Opioid-Induced Psychotic Disorder With Delusions  
- Opioid-Induced Psychotic Disorder With Hallucinations  
- Opioid-Induced Sexual Dysfunction  
- Opioid-Induced Sleep Disorder

**Internet Resources**

- [http://www.intox.org/databank/documents/treat/treate/trt38_e.htm](http://www.intox.org/databank/documents/treat/treate/trt38_e.htm)  
- [http://www.cochrane.org/cochrane/revabstr/AB002025.htm](http://www.cochrane.org/cochrane/revabstr/AB002025.htm)  
**OPPOSITIONAL DEFIANT**

**Code Number:** 313.81  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**

*Four or more of the following* over six months the individual has repeatedly exhibited defiant, hostile, negativistic behavior: 1) loses temper; 2) argues with adults; 3) defies and refuses to follow the rules and requests of adults; 4) deliberately annoys others; 5) blames others for their own mistakes or behavior; 6) touchy or easily annoyed by others; 7) angry and resentful; 8) spiteful and vindictive.

Some symptoms began before age seven impairs school, social or work functioning.

**Specifiers, Codes and Comments**

- Oppositional Defiant Disorder is part of a subgroup of Conduct Disorders.
- Studies suggest that approximately 2% to 16% may suffer from Oppositional Defiant Disorder

<table>
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<td>☒ Moderate to Severe</td>
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<tr>
<td>Severe</td>
<td>Time off</td>
<td></td>
</tr>
</tbody>
</table>

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

- Conduct Disorder
- Mood Disorder
- Psychotic Disorder
- Child or Adolescent Antisocial Behavior

**Internet Resources**

- [http://www.mentalhealth.com/dis/p20-ch05.html](http://www.mentalhealth.com/dis/p20-ch05.html)
PAIN

Code Number: 307.8x  Category: Somatoform

Behavioral Presentation
- Individual presents with pain in one or more anatomical sites.
- Onset, maintenance, severity, or worsening of pain are psychologically manifested.

Specifiers, Codes and Comments
- Associated With a General Medical Condition – (Code – None).
- Acute – less than six months.
- Chronic – longer than six months.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- TIME OFF

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- TIME OFF

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Conversion Disorder
Dyspareunia
Factitious Disorder
Malingering
Somatization Disorder

Internet Resources
http://www.psychnet-uk.com/dsm_iv/pain_disorder.htm
http://www.behavenet.com/capsules/disorders/paindisorder.htm
http://psychcentral.com/disorders/sx61.htm
http://www.pennhealth.com/ency/article/000922.htm
PANIC ATTACK

Code Number: None
Category: Anxiety

Behavioral Presentation

Four or more of the following over a distinct period of time reaching a peak in 10 minutes: 1) accelerated heart rate, palpitations or pounding heart; 2) sweating; 3) trembling or shaking; 4) shortness or breathing of feeling smothered; 5) choking feelings; 6) chest pain or discomfort; 7) nausea or abdominal distress; 8) feeling dizzy, unsteady, lightheaded, or faint; 9) Derealization, or Depersonalization; 10) fear of losing control or going crazy; 11) fear of dying; 12) parenthesis; 13) chills or hot flashes.

Specifiers, Codes and Comments

Code the specific diagnosis for the Panic Attack.

Studies suggest that possibly 30% of all adults may experience one or more Panic Attacks.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Anxiety Disorder

Internet Resources

http://www.apa.org/pubinfo/panic.html
http://www.adaa.org/AnxietyDisorderInfor/PanicDisAgor.cfm
http://www.panic-attacks.co.uk/
# PANIC DISORDER WITH AGORAPHOBIA

**Code Number:** 300.21  
**Category:** Anxiety

## Behavioral Presentation

*Four or more of the following:* recurrent, unexpected Panic Attack (Pg. 234) consisting of: 1) chest pain or discomfort; 2) chills or hot flashes; 3) choking sensation; 4) feeling unreal or detached; 6) dizzy, lightheaded faint or unsteady; 7) fear of dying; 8) fear of loss of control or becoming insane; 9) heart pounding or racing or skipping beats; 10) nausea or abdominal pain; 11) numbness or tingling; 12) sweating; 13) shortness of breath or smothering sensation; 14) trembling.

*One or more of the following* for a month or more after at least one attack, experiences: 1) concern about more attacks; 2) their significance and consequences; 3) change of behavior to avoid the attacks.

## Specifiers, Codes and Comments

- Panic Disorder without Agoraphobia is part of a subgroup of Panic and Agoraphobia.
- Has Agoraphobia.
- Studies suggest that approximately 1% to 2% of the general population may suffer from Panic Disorder with Agoraphobia.

## Degree of Impairment

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<td>Medical Attention</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
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<tr>
<td>✗ Moderate to Severe</td>
<td>Change of Location</td>
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</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
<td></td>
</tr>
</tbody>
</table>

## Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

## Psychopharmacology

- ✗ Medications
- ✗ Natural Substance

## Warning

Medications and natural substances should be used with a doctor’s approval.

## Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Anorexia Nervosa  
- Bulimia Nervosa  
- Generalized Anxiety Disorder  
- Hypochondriasis Disorder  
- Major Depressive  
- Panic Disorder without Agoraphobia  
- Posttraumatic Stress Disorder  
- Psychotic, Schizoid Personality  
- Separation Anxiety  
- Social Phobia  
- Somatization Disorder  
- Specific Phobia

## Internet Resources
PANIC DISORDER WITHOUT AGORAPHOBIA

**Behavioral Presentation**

*Four or more of the of the following*, recurrent, unexpected Panic Attack (Pg. 234) consisting of:
1) chest pain or discomfort; 2) chills or hot flashes; 3) choking sensation; 4) feeling unreal or detached; 6) dizzy, lightheaded faint or unsteady; 7) fear of dying; 8) fear of loss of control or becoming insane; 9) heart pounding, or racing or skipping beats; 10) nausea or abdominal pain; 11) numbness or tingling; 12) sweating; 13) shortness of breath or smothering sensation; 14) trembling.

*One or more of the following* for a month or more after at least one attack, experiences: 1) concern about more attacks; 2) their significance and consequences; 3) change of behavior to avoid the attacks.

**Specifiers, Codes and Comments**

- Panic Disorder without Agoraphobia is part of a subgroup of Panic and Agoraphobia.
- Does not have Agoraphobia.
- Studies suggest that approximately 1% to 2% of the general population may suffer from Panic Disorder without Agoraphobia.

**Degree of Impairment**

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning**: Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Generalized Anxiety Disorder
- Hypochondriasis Disorder
- Major Depressive Disorder
- Panic Disorder with Agoraphobia
- Posttraumatic Stress Disorder
- Psychotic Disorder
- Schizoid Personality
- Separation Anxiety
- Social Phobia
- Somatization Disorder
- Specific Phobia
Internet Resources
http://www.psyweb.com/Mdisord/DSM_IV/jsp/Axis_I.jsp
http://www.healthyplace.com/Communities/Anxiety/nimh/library/gettingtreatment.asp
PARANOID PERSONALITY

**Code Number:** 301.0 **Category:** Personality

**Behavioral Presentation**
- Suspicious and distrustful of others. On the offensive; responds by taking offense.
- *Four or more of the following:* 1) unfounded belief others are deceiving, exploiting or harming them; 2) preoccupied with doubts of the loyalty or trustworthiness of others; 3) afraid personal information will be used against them; 4) perception there is hidden, threatening or demeaning meaning behind comments of others; 5) bears grudges; 6) believes their reputation or character is being personally attacked and responds by taking a counterattack; 7) suspicious about the fidelity of a significant other.
- Affects others.
- Has lasted some time.

**Specifiers, Codes and Comments**
- Specify, *premorbid* if Schizoid Personality is fulfilled prior to a diagnosis of Paranoid Personality Disorder.
- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Paranoid Personality is part of Cluster “A” disorders.
- Overall they are described as withdrawn, cold, suspicious, or irrational.
- Studies suggest that approximately 0.5% to 2.5% of the general population, 10% to 30% psychiatric inpatients and 2% to 10% of psychiatric outpatients may suffer from Paranoid Personality Disorder.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Antisocial Personality
Avoidant Personality
Borderline Personality
Delusional Disorder, Persecutory Type
Histrionic Personality
Mood Disorder with Psychotic Features
Narcissistic Personality
Schizoid Personality
Schizophrenia
Paranoid Type

Internet Resources
http://www.mentalhealth.com/dis/p20-pe01.html
http://www.toad.net/~arcturus/dd/paranoid.htm
http://www.bullyonline.org/workbully/ppd.htm
http://topcondition.com/images/mymindfield/paranoid_personality_disorder.htm

PARENT-CHILD RELATIONAL PROBLEM

Code Number: V61.20
Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Interaction between a parent(s) and child(ren) such as communication, ineffective discipline, or overprotection cause clinical problems.

Specifiers, Codes and Comments

Degree of Impairment

<table>
<thead>
<tr>
<th>Very Mild</th>
<th>Mild</th>
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<th>Moderate</th>
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</table>

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://healthinmind.com/english/relatpr.htm
http://www.theraplay.org/articles/article17.htm
http://facstaff.uindy.edu/~rholigrocki/Projects.htm
PARTNER RELATIONAL PROBLEM

Code Number: V61.1

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Problems associated with symptoms or negative effects on the functioning between spouses or significant others. These problems may include communication or the absence of communication.

Specifiers, Codes and Comments

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</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://healthinmind.com/english/relatpr.htm
http://www.englishdiscourse.org/edr.1.3diamond.html
PASSIVE-AGGRESSIVE PERSONALITY

Code Number: None  
Category: Personality

Behavioral Presentation

Four or more of the following: 1) resists completing social and occupational jobs on a passive basis; 2) complains others do not understand them or that they are unappreciated; 3) flat and argumentative; 4) scorns and criticizes authority; 4) resents those who have had success or more affluence; 5) overstates misfortune; 6) swings from regret to hostility.

Specifiers, Codes and Comments

Personality problems begin in early adult life. 
Passive-Aggressive Personality Disorder is not part of a cluster. At the time of the writing of this book this disorder is not an official part of the Personality Disorders.
Passive-Aggressive Personality Disorder was previously known as, Negativistic Personality Disorder.

Degree of Impairment  
Very Mild  
Mild  
Mild to Moderate  
Moderate  
Moderate to Severe  
Severe

Suggested Course of Action  
Medical Attention  
Therapy/Counseling  
Support Group  
Special Needs  
Change of Location  
Time off

Psychopharmacology  
Medications  
Natural Substance  
None Suggested  
Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Dysthymic Disorder  
Major Depressive Episode  
Oppositional Defiant Disorder

Internet Resources

http://www.toad.net/~arcturus/dd/papd.htm
http://www.geocities.com/ptypes/passive-aggpd.html
http://health.yahoo.com/ency/adam/000943/overview
http://www.peaceandhealing.com/personality/passive.asp
**PATHOLOGICAL GAMBLING**

**Code Number:** 312.31  
**Category:** Impulse Control

**Behavioral Presentation**
- Preoccupation with gambling, reliving past experiences, and needs more money to increase the amount of gambling.
- Tries and fails at controlling gambling behavior.
- Lies, steals, cheats, embezzles, forges, defrauds, and borrows to get money.
- Jeopardizes relationships, jobs, career advancement, and education.

**Specifiers, Codes and Comments**

- Gambling is a common leisure behavior. It is only when it becomes an overwhelming need that the category is applied to the individual.
- There is a tendency to confuse Pathological Gambling with Substance-Related Disorders. Because of the nature of the impulse the disorders should be kept separate.
- Studies suggest that approximately 0.4% to 3.4% of adults and 2.8% to 8% of adolescents and college students may suffer from Pathological Gambling.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

**Internet Resources**
- http://www.addictionrecov.org/aboutgam.htm
- http://www.psychnet-uk.com/dsm_iv/pathological_gambling.htm
**PEDOPHILIA**

**Code Number:** 302.2  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Strong sexual impulse, fantasy, or behavior involving children, usually under the age of 13.
- The behavior takes place for six months or more.

**Specifiers, Codes and Comments**
- Sexually Attracted to Males.
- Sexually Attracted to Females.
- Sexually Attracted to Males and Females.
- Limited to Incest.
- Exclusive Type–attracted only to children.
- Nonexclusive Type.

Pedophilia is in a subgroup of Paraphilias.

The individual’s primary sexual experience is maintained in the preferred activities associated with a particular paraphilia.

It is estimated that approximately 50% of those seen for a paraphilia are married.

Paraphilia means abnormal or unnatural attraction.

From Greek – *pais, paidos*, a boy or child + *philos*, loving; *phileein*, to love + *-ia*, indicating a condition or quality.

**Degree of Impairment**

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<td>Support Group</td>
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<tr>
<td></td>
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</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Dementia  
Exhibitionism  
Fetishism  
Frotterism  
Gender Identity Disorder  
Manic Episode  
Mental Retardation  
Schizophrenia  
Transvestic Fetishism  
Voyeurism.

**Internet Resources**
http://www.umkc.edu/sites/hsw/issues/pedophil.html
http://www.narth.com/docs/pedophNEW.html
http://sycophants.info/pedophilia.html
http://blogcritics.org/archives/2005/02/02/084240.php
PHASE OF LIFE PROBLEM

Code Number: V62.89  
Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Individual has problems moving from one phase of life such as marriage, divorce, new jobs, or retirement, to another phase.

Specifiers, Codes and Comments

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<td>☒ Moderate</td>
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</tbody>
</table>

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Adjustment Disorder

Internet Resources
http://healthinmind.com/english/addcon.htm
http://www.aafp.org/x16550.xml
http://www.aabibliography.com/psychsnydrome.htm
PHENCYCLIDINE ABUSE

Code Number: 305.00

Category: Substance-Related

Behavioral Presentation

Over one twelve-month period Phencyclidine intake causes clinical distress and impairment.

One or more of the following within a twelve-month period: 1) affects work, social and leisure functioning; 2) continues to use Phencyclidine in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using and recovering from the effects of phencyclidine; 5) Phencyclidine abuse leads to legal problems; 6) continues use in spite of knowing the effects on work, social and personal problems.

Specifiers, Codes and Comments

Phencyclidine Abuse is part of the subgroup of Phencyclidine Use Disorders.

Phencyclidines consist of substances such as Ketamine.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
  None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Phencyclidine Dependence
Phencyclidine-Induced Generalized Anxiety
Phencyclidine-Induced Mood Disorder
Phencyclidine-Induced Psychotic Disorder with Delusions
Phencyclidine Dependence
Phencyclidine Intoxication Delirium

Internet Resources

http://omni.ac.uk/browse/mesh/D010623.html
http://www.druglibrary.org/schaffer/MISC/pcpvio.htm
PHENCYCLIDINE DEPENDENCE

Code Number: 304.90

Category: Substance-Related

Behavioral Presentation
Over one twelve-month period Phencyclidine intake causes clinical distress and impairment. *Three or more of the following occur:*: 1) more Phencyclidine is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for using and recovering from the effects of Phencyclidine; 7) affects work, social and leisure functioning; 8) continues to use a Phencyclidine in spite of its negative physical and psychological effects.

Specifiers, Codes and Comments

- **Early Full Remission** – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
- **Early Partial Remission** – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
- **Sustained Full Remission** – for twelve months or longer does not meet criteria for Abuse or Dependence.
- **Sustained Partial Remission** – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.
- **In a Controlled Environment** – is in a controlled environment—hospital or inpatient clinic.

Phencyclidine is part of the subgroup of Phencyclidine Use Disorders.

Phencyclides consist substances such as Ketamine.

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Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Phencyclidine Abuse
Phencyclidine-Induced Generalized Anxiety
Phencyclidine-Induced Mood Disorder
Phencyclidine-Induced Psychotic Disorder with Delusions
Phencyclidine Intoxication Delirium

Internet Resources
http://www.mentalhealth.com/dis/p20-sb09.html
http://www.azpsychiatry.info/icd/substance/dependence/phencyclidine.htm
http://faculty.washington.edu/chudler/pcp.html
http://www.emedicine.com/med/topic3118.htm
PHENCYCLIDINE INTOXICATION

Code Number: 292.89

Category: Substance-Related

Behavioral Presentation

- Recent intake of Phencyclidine or related substance causing maladaptive behavior and psychological effects including assault, belligerence, impulsivity, agitation, unpredictability, impaired judgment, impaired work, and social functioning.
- Two or more of the following within an hour of use or less if substance is snorted, smoked or injected: 1) involuntary rhythmic eye movement; 2) numbness or decreased response to pain; 3) unstable walking; 4) trouble speaking; 5) rigid muscles; 6) coma and seizures; 7) abnormally acute hearing.

Additional Notations and Specifiers, Codes and Comments

With Perceptual Disturbances – auditory, visual illusions; tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).

Phencyclidine Intoxication is part of the subgroup of Phencyclidine-Induced Disorders.

Phencyclidines consist substances such as Ketamine.

From Latin – intoxicare, to poison, + toxicum, poison + -ation, indicating a process or condition.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Phencyclidine Abuse
Phencyclidine Dependence
Phencyclidine-Induced Generalized Anxiety
Phencyclidine-Induced Mood Disorder
Phencyclidine-Induced Psychotic Disorder with Delusions
Phencyclidine Dependence
Phencyclidine Intoxication Delirium

Internet Resources

http://www.vh.org/adult/provider/psychiatry/CPS/29.html
http://www.drugs.com/phencyclidine.html
http://www.emedicine.com/med/topic1813.htm
PHONOLOGICAL

**Code Number:** 315.39  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**
- Unexpected speech sounds for individual’s age and dialect, i.e., substituting consonant sounds for one another, omitting final consonants.
- Education, occupational achievement or social communication are interrupted.

**Specifiers, Codes and Comments**
- Phonological Disorder is part of a subgroup of Communication Disorders.
- Phonological Disorder was formerly known as Developmental Articulation Disorder.
- Code all sensory deficits or neurological conditions on Axis III.
- Mental retardation, environmental deprivation, speech-motor, or sensory deficit may worsen the individual’s problem.
- Developmental language delays are more common than acquired language delays.
- Studies suggest that approximately 2% of 6 to 7 year-old children may suffer from moderate to severe Phonological Problems.

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**Alternate Diagnostic Presentation**

_Always rule out_ General Medical Conditions  
_Always rule out_ Substance Related Disorders

Communication Disorder  
Mental Retardation  
Stuttering

**Internet Resources**
- [http://www.psychnet-uk.com/dsm_iv/phonological_disorder.htm](http://www.psychnet-uk.com/dsm_iv/phonological_disorder.htm)  
- [http://members.tripod.com/Caroline_Bowen/phonol-and-artic.htm](http://members.tripod.com/Caroline_Bowen/phonol-and-artic.htm)  
- [http://members.tripod.com/%7ECaroline_Bowen/clinphonology.html](http://members.tripod.com/%7ECaroline_Bowen/clinphonology.html)  
PHYSICAL ABUSE OF ADULT

Code Number: V61.1

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Problems relating to the abuse, physical or psychological, of an elder or spouse.

Specifiers, Codes and Comments
If the clinical attention is focused on the victim use (Code – 995.81)

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | ☒ Medical Attention | Medications
Mild | ☒ Therapy/Counseling | Natural Substance
Mild to Moderate | ☒ Support Group | ☒ None Suggested
Moderate | ☒ Special Needs | Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe | ☒ Change of Location | ☒ None Suggested
Severe | ☒ Time off | Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.psych.org/pnews/96-09-06/icd.html
http://ajp.psychiatryonline.org/cgi/content/full/155/1/131
http://www.ingentaconnect.com/content/sage/j332/2002/00000007/00000003/art00006
PHYSICAL ABUSE OF CHILD

Code Number: V61.21  
Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Problems relating to the physical abuse of a child.

Specifiers, Codes and Comments

If the clinical attention is focused on the perpetrator and the abuse is by the partner use (Code – V61.12).
If the clinical attention is focused on the perpetrator and the abuse is by someone other than the partner use (Code – V62.83).
If the clinical attention is focused on the victim use (Code – 995.81).

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | Medical Attention | Medications |
Mild | Therapy/Counseling | Natural Substance |
Mild to Moderate | Support Group | None Suggested |
Moderate | Special Needs | Warning: Medications and natural substances should be used with a doctor’s approval. |
Moderate to Severe | Change of Location | |
Severe | Time off | |

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Internet Resources
http://www.childresearch.net/CYBRARY/NEWS/200012.HTM
http://www.ipt-forensics.com/journal/volume5/j5_1_4.htm
http://healthinmind.com/english/abuneg.htm
http://www.lsa.org.uk/lsa32.htm
PICA

Code Number: 307.52

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

- For one month or more, the individual eats dirt or non-nutritive substances.
- Developmentally inappropriate to the individual’s age.
- Not a part of the individual’s culture.

Specifiers, Codes and Comments

- Pica is part of a subgroup of Feeding and Eating Disorders of Infancy or Early Childhood.
- Studies suggest that approximately 15% of the Severely Mentally Retarded may have suffer from Pica.
- From Latin – *pica*, a magpie, referring to its fondness for inedible objects.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Kleine-Levin Syndrome
Pervasive Developmental Disorder
Schizoid Personality.

Internet Resources

http://www.psychnet-uk.com/dsm_iv/pica_disorder.htm
http://www.emedicine.com/ped/topic1798.htm
POSTTRAUMATIC STRESS

Code Number: 309.81 Category: Anxiety

Behavioral Presentation

- Witnessed or directly experienced both: an actual or threatened death, physical injury to self or others and felt intense fear, horror or helplessness.
- *One or more of the following:* relives the events in: 1) distressing dreams; 2) thoughts or recollections; 3) flashbacks, hallucinations, or illusions; 4) mental distress resulting from internal or external cues; 5) physical reaction to the internal or external cues.
- *Three or more of the following:* 1) avoids thoughts, feelings or conversations about the event; 2) avoids activities, places or people that cause memories of the event; 3) less interest in normal activities; 4) detachment or estrangement; 5) restricted affect; 6) feels that they have no future.
- *Two or more of the following* during or after the event: 1) problems falling or remaining asleep; 2) irritable or has anger outbursts; 3) problems with concentration; 4) hypervigilant; 5) above-normal startle response.
- Must exist one month or more.

Specifiers, Codes and Comments

- **Acute** – if 3 months or less.
- **Chronic** – if 3 months or more.
- **With Delayed Onset** – onset occurs 6 months after the event.

Posttraumatic Stress Disorder (PTSD) is most commonly associated with war veterans. However, PTSD may result from any trauma such as rape, automobile accidents, drowning, near-death, kidnaping, spouse abuse, and more. The longer the duration of the trauma the greater the chance of acquiring of PTSD.

Studies suggest that approximately 8% of the adult population may suffer from PTSD.

From Latin – *post,* after and Greek – *trauma,* a wound.

Degree of Impairment  Suggested Course of Action  Psychopharmacology
- Very Mild  ✗ Medical Attention  ✗ Medications
- Mild  ✗ Therapy/Counseling
- Mild to Moderate  ✗ Support Group
- Moderate  ✗ Special Needs
- Moderate to Severe  ✗ Change of Location  ✗ Natural Substance
- Severe  ✗ Time off  None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Acute Stress Disorder
Adjustment Disorder
Malingering
Mood Disorder with Psychotic Features
Obsessive-Compulsive Personality
Schizophrenia
Psychotic Disorder

**Internet Resources**
http://www.mentalhealth.com/dis/p20-an06.html
http://www.ncptsd.org/
http://www.aacap.org/publications/factsfam/ptsd70.htm
http://www.nmha.org/reassurance/ptsd.cfm
PREMATURE EJACULATION

Code Number: 302.75
Category: Sexual and Gender Identity

Behavioral Presentation
- Minimal sexual stimulation, including visual, brings about an earlier-than-desired ejaculation.
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

Specifiers, Codes and Comments
- **Lifelong Type** – has existed for the individual’s entire sexual life.
- **Acquired Type** – exists for periods of time.
- **Generalized Type** – exists with any partner or sexual activity.
- **Situational Type** – exists only with certain partners or situations.
- **Due to Psychological Factors** – only psychological issues.
- **Due to Combined Factors** – both psychological and physical issues.
- Premature Ejaculation Disorder is part of the Orgasmic Disorders which are a subgroup of Sexual Dysfunctions.
- From Latin – praematurus, unduly early; prae, before + maturus, ripe + iaculatus, thrown; iacere, to throw; ation, indicating a process or condition.

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</table>

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Internet Resources
http://my.webmd.com/content/article/53/61404.htm
http://psychcentral.com/disorders/sx64.htm
http://allpsych.com/disorders/sexual/ejaculation.html
http://www.psychnet-uk.com/dsm_iv/premature_ejaculation.htm
PRIMARY HYPERSOMNIA

Behavioral Presentation

For a month or more (less if recurrent), the individual experiences excessive sleepiness exhibited by prolonged sleep or sleeping during the day, almost daily.

Specifiers, Codes and Comments

- Recurrent – sleepiness lasts three days or more for at least two years.
- Primary Hypersomnia is part of a subgroup of Dyssomnias.
- Studies suggest that approximately 5% to 10% of the population with sleep disorders may suffer from this Primary Hypersomnia.
- Studies suggest that approximately 0.5% to 5.0% may suffer from daytime sleepiness with a lifetime aggregate of 16% or more.
- Kleine-Levine Syndrome, a rare Recurrent type of Primary Hypersomnia, is associated with as much as 20 hours of sleep, compulsive overeating, weight gain, irritability, and inappropriate sexual behavior.

- Dyssomnias from Greek – dys, bad or abnormal + somnus, sleep.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Bipolar I Disorder
Breathing-Related Sleep Disorder
Caucasian Rhythm Sleep Disorder
Primary Insomnia
Major Depressive Episode
Major Depressive Episode with Atypical Features
Narcolepsy

Internet Resources

http://www.emedicine.com/med/topic3129.htm
http://www.psychnet-uk.com/dsm_iv/hypersomnia.htm
http://allpsych.com/disorders/sleep/hypersomnia.html
http://www.talkaboutsleep.com/sleepdisorders/Snoring_apnea_abstract85.htm
PRIMARY INSOMNIA

Code Number: 307.42  
Category: Sleep

Behavioral Presentation

► For one month or more the individual has trouble going to sleep, staying a sleep or feeling rested after sleep.
► Daytime fatigue.

Specifiers, Codes and Comments

❖ Primary Insomnia is part of a subgroup of Dyssomnias.
❖ Studies suggest that approximately 1 to 10% of the adult population and 25% of the elderly may suffer from this Primary Insomnia.
❖ Studies suggest that 15% to 25% of those with chronic insomnia may be diagnosed with Primary Insomnia.
❖ Dyssomnias, from Greek – dys, bad or abnormal + somnus, sleep.

Degree of Impairment  Suggested Course of Action  Psychopharmacology
Very Mild  ☒ Medical Attention
Mild  ☒ Therapy/Counseling
Mild to Moderate  ☒ Support Group
Moderate  ☒ Special Needs
☒ Moderate to Severe  ☒ Change of Location
Severe  ☒ Time off

Psychopharmacology
☒ Medications
☒ Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Breathing-Related Sleep Disorder
Circadian Rhythm Sleep Disorder
Mood Disorder
Narcolepsy
Nightmare Disorder
Primary Hypersomnia
Sleep Terror
Sleep Apnea
Sleepwalking Disorder

Internet Resources
http://www.aafp.org/afp/990600ap/3029.html
http://www.psychnet-uk.com/dsm_iv/primary_insomnia.htm
http://www.wrongdiagnosis.com/p/primary_insomnia/intro.htm
PSYCHOLOGICAL FACTOR AFFECTING MEDICAL CONDITION

Code Number: 316  Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Individual has a general medical condition.
One or more of the following psychological factors affects the medical condition: 1) development, worsening, or delay of recovery from the condition; 2) interferes with medical condition; 3) worsens the risk to the patient’s health; 4) stress evokes and worsens the medical condition.

Specifiers, Codes and Comments
- Mental Disorder Affecting – mental condition delays recovery from physical condition.
- Psychological Symptoms Affecting Not Otherwise Specified – mental condition delays recovery from physical condition.
- Personality Traits or Coping Style Affecting – maladaptive style of coping affects recovery from physical condition.
- Maladaptive Health Behaviors Affecting – dysfunctional lifestyle affects recovery from physical condition.
- Stress-Related Physiological Response Affecting – stress affects recovery from physical condition.
- Other or Unspecified Psychological Factors Affecting – other factors affect recovery from physical condition.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation
Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Pain Disorder
Somatoform Disorder
Substance-Related Disorder

Internet Resources
http://healthinmind.com/english/psychmc.htm
http://psy.psychiatryonline.org/cgi/content/abstract/32/1/5
http://www.behavenet.com/capsules/disorders/psyfactorsmedcon.htm
http://www.brooks.af.mil/web/consult_service/waiver%20guide/Psychiatry/Psychological%20Factors%20Affecting%20Medical%20Conditions.htm
PYROMANIA

Code Number: 312.33 Category: Impulse Control

Behavioral Presentation
The individual sets fires for pleasure rather than: 1) for profit; 2) to conceal crimes; 3) anger; 4) revenge; 5) to improve living conditions; 6) in response to hallucinations; 7) delusions; 8) political agenda; 9) a result of impaired judgment.

Specifiers, Codes and Comments
• Once the individual feels tension and emotion there is an overwhelming need to set a fire; as a result of setting a fire, the individual feels pleasure, gratification and relief.
• Men dominate this category. Individuals may make advance preparations through searching out a site and collecting materials to light.
• Pyromania is also known as Fire Setting or Fire Starter.
• From Greek – pyr, fire + mania, madness.

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
Very Mild | Medical Attention | Medications
Moderate | Support Group | None Suggested
Severe | Change of Location | Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation
Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Antisocial Personality
Bipolar I Disorder
Most Recent Episode Manic
Cognitive Disorder
Conduct Disorder
Schizophrenia

Internet Resources
http://www.crescentlife.com/disorders/pyromania.htm
http://healthinmind.com/english/pyrom.htm
http://www.psychnet-uk.com/dsm_iv/pyromania.htm
REACTIVE ATTACHMENT OF INFANCY AND CHILDHOOD

**Code Number:** 313.89

**Category:** Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence

**Behavioral Presentation**

- Beginning before age five, in most situations, the individual has markedly social relatedness, inappropriate disturbance and development.
- **INHIBITIONS:** exhibited in social situations individual is excessively inhibited, hypervigilant or ambivalent and contradictory, i.e., responds to caregivers with frozen watchfulness or mixed approach–avoidance.
- **DISINHIBITIONS:** exhibited though diffuse selective attachments, i.e., overly familiar with strangers or lacks selectiveness in choosing attachments.
- *One or more of the following* as a result of persistent pathogenic care: 1) care-giver neglects individual’s basic emotional need for affection, comfort, stimulation; 2) care-giver neglects child’s basic physical needs; 3) care-givers are changed causing unstable attachments.

**Specifiers, Codes and Comments**

- **Inhibited Type** – failure to engage or interact, socially, at the developmentally expected age.
- **Disinhibited Type** – inability to make good decisions, engage or interact, socially, at the developmentally expected age.

Reactive Attachment Disorder of Infancy or Early Childhood is part of a subgroup of Other Disorders of Infancy, Childhood, or Adolescence.

**Degree of Impairment**

- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- Attention-Deficit/Hyperactivity Disorder
- Autistic
- Conduct Disorder
- Mental Retardation
- Oppositional Defiant Disorder
- Pervasive Developmental Disorder
- Social Phobia

**Internet Resources**

http://www.emedicine.com/ped/topic2646.htm
http://www.shands.org/health/information/article/001547.htm
http://www.drkoop.com/ency/article/001547.htm
READING

**Code Number:** 315.00

**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**

- Ability to read both for accuracy and comprehension is markedly less than expected given the individual’s age, intelligence and education.
- The reading problem impedes academic achievement and daily living.

**Specifiers, Codes and Comments**

- Learning Disorders were formerly known as Academic Skills Disorders.
- Reading Disorders are part of a subgroup of Learning Disorders.
- Code all sensory deficits or General Medical Conditions on Axis III.
- Studies suggest that approximately 5% of all public school students may suffer from Learning Disorders.
- Studies suggest that approximately 4% of all school age children may suffer from Reading Disorders.

**Degree of Impairment**

- Very Mild
- Mild
- **Mild to Moderate**
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**

- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- *Always rule out* General Medical Conditions
- *Always rule out* Substance Related Disorders

**Internet Resources**

- [http://www.athealth.com/Consumer/disorders/Reading.html](http://www.athealth.com/Consumer/disorders/Reading.html)
- [http://www.familyschool.com/Perezdyslexia/PerezDA/reading.htm](http://www.familyschool.com/Perezdyslexia/PerezDA/reading.htm)
- [http://www.shands.org/health/information/001406.htm](http://www.shands.org/health/information/001406.htm)
- [http://health.yahoo.com/ency/adam/001406/overview](http://health.yahoo.com/ency/adam/001406/overview)
RELATIONAL PROBLEM RELATED TO A MENTAL DISORDER OR GENERAL MEDICAL CONDITION

Code Number: V61.9
Category: Other Conditions That May Be a Focus Of Clinical Attention

Behavioral Presentation
Problems resulting from an interaction with a relative or significant other who has a mental or physical disorder.

Specifiers, Codes and Comments

Degree of Impairment | Suggested Course of Action | Psychopharmacology
--- | --- | ---
 Very Mild | ☒ Medical Attention | Medications
 Mild | ☒ Therapy/Counseling | Natural Substance
 ☒ Mild to Moderate | ☒ Support Group | ☒ None Suggested
 Moderate | ☒ Special Needs | Warning: Medications and natural substances should be used with a doctor’s approval.
 Moderate to Severe | Change of Location | Time off
 Severe | | |

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.mentalhealth.com/help/p10-dis2.html
http://smhp.psych.ucla.edu/conted2/dsm.htm
http://www.aafp.org/afp/991115ap/2311.html
http://www.appi.org/book.cfm?id=2074
RELIGIOUS OR SPIRITUAL PROBLEM

Code Number: V62.89

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation
Individual has problems with issues of religion and faith.

Specifiers, Codes and Comments

Degree of Impairment  Suggested Course of Action  Psychopharmacology
Very Mild  Medical Attention  Medications
Mild  Therapy/Counseling  Natural Substance
Mild to Moderate  Support Group  None Suggested
Moderate  Special Needs  Warning: Medications and natural substances should be used with a doctor’s approval.
Moderate to Severe  Change of Location
Severe  Time off

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://www.balmnet.co.uk/spirituality.htm
http://www.meta-religion.com/Psychiatry/Demonic_possesion/possession_experience.htm
RETT’S SYNDROME

Code Number: 299.80 Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- After a normal beginning: 1) between 5 and 48 months, abnormal head growth occurs; 2) loss of acquired purposeful hand movement; 3) develops stereotyped hand movements, i.e., hand washing and hand wringing; 4) loses interest in social environment (often later develops social interaction); 5) poor coordination of gait and movements; 6) severe psychomotor retardation; 7) expressive and receptive language impairment.

Specifiers, Codes and Comments
- There is normal prenatal and perinatal development, psychomotor development at least until the age of five months with normal head circumference at birth.
- Rett’s Syndrome is part of a subgroup of Pervasive Developmental Disorders.
- Mental retardation, environmental deprivation, speech-motor, or sensory deficit may worsen the individual’s problem.
- Rett’s Syndrome is found only in females.
- Studies suggest that Rett’s Syndrome is not as common as Autism.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation
- Always rule out General Medical Conditions
- Always rule out Substance Related Disorders

Asperger’s
Autistic
Childhood Disintegrative Disorder

Internet Resources
- http://info.med.yale.edu/chldstdy/autism/retts.html
- http://ajp.psychiatryonline.org/cgi/content/full/159/8/1294
RUMINATION

Code Number: 307.53

Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- For one month or more the individual repeatedly regurgitates and re-chews food.
- Individual has functioned normally until the point of Rumination.
- Not a result of Anorexia Nervosa, Bulimia Nervosa, a gastrointestinal illness, or General Medical Condition.

Specifiers, Codes and Comments
- Rumination is part of a subgroup of Feeding and Eating Disorders of Infancy or Early Childhood.
- The problem may exist more in males than in females.
- From Latin – *ruminare*, to chew the cud; from *rumen*, the gullet

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

Anorexia
Bulimia

Internet Resources
http://www.psychnet-uk.com/dsm_iv/rumination_disorder.htm
http://www.emedicine.com/ped/topic2652.htm
http://psychcentral.com/disorders/sx77.htm
SCHIZOAFFECTIVE

Code Number: 295.70

Category: Schizophrenia and Other Psychotic Disorders

Behavioral Presentation

Continuous Depressive Episodes, Manic Episodes or Mixed Episodes with Schizoid Personality criteria “A.”

Two weeks or more during the active phase the individual has delusions and hallucinations.

For most of the time during the mood episode of the active and residual periods, symptoms are present.

Specifiers, Codes and Comments

Bipolar Type – Manic Episode or Mixed Episode, Major Depressive Episode.

Depressive Type – Major Depressive Episode.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Delirium
Dementia
Mood Disorder with Psychotic Features
Schizoid Personality

Internet Resources

http://www.mentalhealth.com/dis/p20-ps05.html
http://www.geometricvisions.com/Madness/schizoaffective-disorder/
http://www.nmha.org/infoctr/factsheets/52.cfm
http://www.nami.org/Content/ContentGroups/Helpline1/Schizoaffective_Disorder.htm
SCHIZOPHRENIFORM

**Code Number:** 295.40  
**Category:** Schizophrenia and Other Psychotic Disorders

**Behavioral Presentation**
- Continuous Depressive Episode, Manic Episode or Mixed Episode active with of Schizophrenia criteria “A.”
- Two weeks or more during the active phase, the individual has delusions and hallucinations.
- For most of the time of the mood episode of the active and residual periods symptoms are present

**Specifiers, Codes and Comments**

*Without Good Prognostic Features.*

*With Good Prognostic Features* – two or more of the following: 1) within 4 weeks of the onset of psychotic symptoms, there is a change from expected behavior or functioning; 2) at the pinnacle of the Psychotic Episode (Pg. 320) there is confusion or perplexity; 3) positive premorbid social and occupational functioning; 4) blunted or flat affect is absent.

From – Schizophreni(a) + form, from Latin – forma, a form.

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<thead>
<tr>
<th>Degree of Impairment</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Mild</td>
<td>☑ Medical Attention</td>
<td>☑ Medications</td>
</tr>
<tr>
<td>Mild</td>
<td>☑ Therapy/Counseling</td>
<td>☑ Natural Substance</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>☑ Support Group</td>
<td>None Suggested</td>
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<tr>
<td>Moderate</td>
<td>☑ Special Needs</td>
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<tr>
<td>Moderate to Severe</td>
<td>☑ Change of Location</td>
<td>Warning: Medications and</td>
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<tr>
<td>☑ Severe</td>
<td>☑ Time off</td>
<td>natural substances should be</td>
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<td></td>
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<td>used with a doctor’s approval.</td>
</tr>
</tbody>
</table>

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*

*Always rule out Substance Related Disorders*

Delirium
Dementia
Mood Disorder with Psychotic Features
Schizoid Personality

**Internet Resources**

http://www.mentalhealth.com/dis/p20-ps05.html  
http://www.nmha.org/infoctr/factsheets/52.cfm  
http://www.psycom.net/depression.central.schizoaffective.html  
http://www.npi.ucla.edu/sgg/schizoaffective.htm
SCHIZOID PERSONALITY

Code Number: 301.20
Category: Personality

Behavioral Presentation
- Few social relationships; restricted emotional range in interpersonal relationships.
- *Four or more of the following:* 1) does not want or like close relationships, including the family; 2) prefers solitary activities; 3) no interest in sexual activity; 4) enjoys few activities; 5) no close friends or confidants other than relatives; 6) not affected by criticism or praise; 7) emotionally cold, detached or bland.
- Affects others.
- Lasted some time.

Specifiers, Codes and Comments
- *Premorbid* – if Schizophrenia is diagnosed after a diagnosis of Schizoid Personality Disorder.
- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Schizoid Personality is part of Cluster “A” disorders.
- Overall they are described as withdrawn, cold, suspicious, or irrational.

Degree of Impairment
- Very Mild
- *Mild*
  - Mild to Moderate
  - Moderate
  - Moderate to Severe
  - Severe

Suggested Course of Action
- *Medical Attention*
- *Therapy/Counseling*
- *Support Group*
- *Special Needs*
- *Change of Location*
- Time off

Psychopharmacology
- *Medications*
- *Natural Substance*
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

Asperger’s
Autistic
Avoidant Personality
Delusional
Mood Disorder with Psychotic Features
Obsessive-Compulsive Disorder
Paranoid Personality
Schizophrenia
Schizotypal Personality

Internet Resources
http://www.mentalhealth.com/dis/p20-pe02.html
http://www.pipeline.com/~dada3zen/schizoid_per_dis.htm
http://www.toad.net/~arcturus/dd/schizoid.htm
Behavioral Presentation

CRITERIA A. One or more of the following: 1) Delusions; 2) hallucinations; 3) disorganized speech; 4) grossly disorganized or Catatonic behavior for one day to one month in duration with complete premorbid recovery. Only one criteria required if delusions are bizarre.

CRITERIA B. One or more of the following dysfunctions during disturbance: 1) work; 2) interpersonal relations; 3) self-care (in childhood and adolescence); 4) interpersonal, academic, or occupational achievement.

CRITERIA C. Last six months or longer with one month or more of criteria “A” symptoms that may include Prodromal or Residual symptoms.

CRITERIA D. Schizoaffective and Mood Disorder with Psychotic Features are ruled out due to no Major Depressive Episodes, Manic Episodes, or Mixed Episodes during the active phase. If the mood episodes occurred they are brief relative to the active and residual periods.

CRITERIA E. Not due to a substance or general medical condition.

CRITERIA F. With a history of Autistic Disorder or Pervasive Developmental Disorder, a diagnosis of Schizophrenia may be made providing Delusions and Hallucinations are present for at least one month.

Specifiers, Codes and Comments

Episodic With Interepisode Residual Symptoms – Criteria “A” with residual symptoms.

With Prominent Negative Symptoms – negative symptoms stand out.

Episodic With No Interepisode Residual Symptoms – Criteria “A” with no residual symptoms.

Continuous – no remission in Criteria “A”

With Prominent Negative Symptoms – negative symptoms stand out.

Single Episode In Partial Remission – one episode of Criteria “A” with residual symptoms.

With Prominent Negative Symptoms – negative symptoms stand out.

Single Episode In Full Remission – no symptoms remain.

Other or Unspecified Pattern

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Communication Disorder
Delirium
Delusional
Dementia
Mood Disorder with Psychotic Features
Paranoid
Pervasive Developmental
Schizoaffective
Schizoid Personality
Schizophrenia Subtypes
Schizotypal Personality

Internet Resources
http://www.schizophrenia.com/
http://www.mentalhealth.com/dis/p20-ps01.html
http://www.schizophrenia.ca/
SCHIZOPHRENIA, CATATONIC TYPE

Code Number: 295.20  
Category: Schizophrenia and Other Psychotic Disorder

Behavioral Presentation

See Schizophrenia.

Two or more of the following: 1) motor immobility or stupor, or 2) non-purposeful hyperactivity; 3) mutism or marked negativism; 4) posturing, stereotypes, mannerisms, or grimacing; 5) Echolalia or Echopraxia.

All are dominant: disorganized speech, inappropriate or flat affect, disorganized behavior.

Specifiers, Codes and Comments

Negativism – refusing to follow instructions or maintains a rigid posture.

Mannerisms – unnecessary movements; movements beyond normal.

Stereotypes – non-goal directed behavior; thumbs up over and over again.

Posturing – spontaneous posing or posturing that is bizarre or inappropriate.

Echolalia – repeating of another person’s words.

Echopraxia – repeating of another person’s body movements or actions.

Studies suggest that approximately 0.5% to 1.5% of adults may suffer from Schizophrenia.

From Greek – schizein, to split + phren, mind, originally midriff, the supposed seat of the soul + -ia, indicating a condition or quality.

Degree of Impairment

<table>
<thead>
<tr>
<th>Very Mild</th>
<th>Suggested Course of Action</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Medical Attention</td>
</tr>
<tr>
<td>Mild</td>
<td>Therapy/Counseling</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
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<tr>
<td>Moderate</td>
<td>Special Needs</td>
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<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
</tr>
</tbody>
</table>

Psychopharmacology

Medications

Natural Substance

None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Brief Psychotic Disorder
Communication Disorder
Delirium
Delusional Disorder
Dementia
Mood Disorder
Paranoid Personality
Pervasive Developmental Disorder
Schizoaffective Disorder
Schizoid Personality

Internet Resources
SCHIZOPHRENIA, DISORGANIZED TYPE

Code Number: 295.10

Category: Schizophrenia and Other Psychotic Disorders

Behavioral Presentation

See Schizophrenia

Does not meet the criteria for Catatonic Type

All are dominant: disorganized speech, inappropriate or flat affect, disorganized behavior.

Specifiers, Codes and Comments

Schizophrenia, Disorganized Type may also be referred to as Hebephrenic.

Studies suggest that approximately 0.5% to 1.5% of adults may suffer from Schizophrenia.

From Greek – schizein, to split + phren, mind, originally midriff, the supposed seat of the soul + -ia, indicating a condition or quality.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Brief Psychotic Disorder
Communication Disorder
Delirium
Delusional Disorder
Dementia
Mood Disorder
Paranoid Personality
Pervasive Developmental
Schizoaffective Disorder
Schizoid Personality

Internet Resources

http://www.ehendrick.org/healthy/000937.htm
http://www.psychnet-uk.com/dsm_iv/schizophrenia_disorder.htm
http://www.psyweb.com/Mdisord/SchizoDis/distype.jsp
SCHIZOPHRENIA, PARANOID TYPE

Code Number: 295.30

Category: Schizophrenia and Other Psychotic Disorder

Behavioral Presentation

See Schizophrenia.

Delusions or frequent auditory hallucinations.

None or dominant: disorganized speech, catatonic behavior, or inappropriate or flat affect, disorganized behavior.

Specifiers, Codes and Comments

Studies suggest that approximately 0.5% to 1.5% of adults may suffer from Schizophrenia.

From Greek – schizein, to split + phren, mind, originally midriff, the supposed seat of the soul + -ia, indicating a condition or quality.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Brief Psychotic Disorder
Communication Disorder
Delirium
Delusional Disorder
Dementia
Mood Disorder
Paranoid Personality
Pervasive Developmental
Schizoaffective Disorder
Schizoid Personality

Internet Resources

http://adam.about.com/encyclopedia/000936.htm
http://www.shands.org/health/information/article/000936.htm
http://www.ehendrick.org/healthy/000936trt.htm
SCHIZOPHRENIA, RESIDUAL TYPE

Code Number: 295.60  
Category: Schizophrenia and Other Psychotic Disorders

Behavioral Presentation

See Schizophrenia.

- Individual at one time meets the criteria for Disorganized Type, Catatonic Type, Paranoid Type, or Undifferentiated Type.
- No longer suffers from Catatonia, Delusions, Hallucinations, or Disorganized speech or behavior.
- Still suffers from one or more of the following: 1) negative symptoms: reduced speech output, lack of volition or flat affect; 2) attenuated delusions, hallucinations, illusion, disorganized speech, or disorganized behavior.

Specifiers, Codes and Comments

- Studies suggest that approximately 0.5% to 1.5% of adults may suffer from Schizophrenia.
- From Greek – schizein, to split + phren, mind, originally midriff, the supposed seat of the soul + -ia, indicating a condition or quality.

Degree of Impairment

<table>
<thead>
<tr>
<th>Very Mild</th>
<th>Mild</th>
<th>Mild to Moderate</th>
<th>Moderate</th>
<th>Moderate to Severe</th>
<th>Severe</th>
</tr>
</thead>
</table>

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance

Warning: Medications and natural substances should be used with a doctor’s approval.

Degree of Impairment

Alternate Diagnostic Presentation

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Always rule out General Medical Conditions

Always rule out Substance Related Disorders

Brief Psychotic Disorder
Communication Disorder
Delirium
Delusional Disorder
Dementia
Mood Disorder
Paranoid Personality
Pervasive Developmental
Schizoaffective Disorder
Schizoid Personality

Internet Resources

http://www.psyweb.com/Mdisord/SchizoDis/redtype.jsp

329
http://mysite.verizon.net/res7oqx1/id9.html#Residual
http://www.hubin.org/publicfamilyinfo/diagnosis/types_en.html
http://www2.una.edu/lbates/Schizophrenia%20notes%20sample%20a.htm
SCHIZOPHRENIA, UNDIFFERENTIATED TYPE

Code Number: 295.90

Category: Schizophrenia and Other Psychotic Disorders

Behavioral Presentation
See Schizophrenia, criteria “A”.
Individual does not meet the criteria for Disorganized Type, Catatonic Type or Paranoid Type.

Specifiers, Codes and Comments
Studies suggest that approximately 0.5% to 1.5% of adults may suffer from Schizophrenia.
From Greek – schizein, to split + phren, mind, originally midriff, the supposed seat of the soul + -ia, indicating a condition or quality.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- ☒ Medical Attention
- ☒ Therapy/Counseling
- ☒ Support Group
- ☒ Special Needs
- ☒ Change of Location
- ☒ Time off

Psychopharmacology
- ☒ Medications
- ☒ Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Brief Psychotic Disorder
Communication Disorder
Delirium
Delusional Disorder
Dementia
Mood Disorder
Paranoid Personality
Pervasive Developmental Disorder
Schizoaffective Disorder
Schizoid Personality

Internet Resources
http://www.psyweb.com/Mdisord/SchizoDis/undtype.jsp
http://www.essaysample.com/essay/002018.html
http://health.yahoo.com/ency/adam/000928/overview
http://www.behavenet.com/capsules/disorders/undifferentiatedschiz.htm
SCHIZOTYPAL PERSONALITY

Code Number: 301.22 Category: Personality

Behavioral Presentation

- Discomfort and isolation with social relationships, perceptual or cognitive distortions, peculiar behavior.
- Five or more of the following: 1) unusual perceptions or body illusions; 2) odd speech; 3) odd beliefs or magical thinking that is not cultural; 4) odd ideas of reference; 5) paranoid or suspicious ideas; 6) constricted range of affect that is not appropriate to the topic; 7) no close friends other than relatives; 8) anxiety in social settings associated with paranoia.
- Close friends are few; lack relationships.
- Social Anxiety that does not lessen as they become familiar with the other person.
- Affects others.
- Has lasted some time.

Specifiers, Codes and Comments

- Premorbid – if Schizoid Personality is diagnosed after a diagnosis of Antisocial Personality Disorder (Pg. 119).
- Personality problems begin in early adult life.
- Personality Disorders are grouped in clusters. Schizotypal Personality is part of Cluster “A” disorders. Overall they are described as withdrawn, cold, suspicious, or irrational.
- Studies suggest that approximately 3.0% of the general population may suffer from Schizotypal Personality Disorder.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Asperger’s
Autistic
Avoidant Personality
Borderline Personality
Communication Disorder
Delusional Disorder
Expressive Language Disorder
Mixed Receptive-Expressive Disorder
Mood Disorder
Narcissistic Personality
Paranoid Personality
Schizoid Personality
Schizoid Personality.

Internet Resources
http://www.mentalhealth.com/dis/p20-pe03.html
http://www.geocities.com/ptypes/schizotypalpd.html
http://www.psyweb.com/Mdisord/scpd.html
SEDATIVE, HYPNOTIC AND ANXIOLYTIC ABUSE

**Behavioral Presentation**

- Over one twelve-month period Sedative, Hypnotic and Anxiolytic intake causes clinical distress and impairment.

- One or more of the following within a twelve-month period: 1) affects work, social, and leisure functioning; 2) continues to use Sedative, Hypnotic and Anxiolytic in spite of its negative physical and psychological effects; 3) tries to control use; 4) spends a lot of time looking for, using and recovering from the effects of Sedative, Hypnotic and Anxiolytic; 5) Sedative, Hypnotic and Anxiolytic abuse leads to legal problems; 6) continues use in spite of knowing the effects on work, social and personal problems

**Specifiers, Codes and Comments**

- Sedative, Hypnotic and Anxiolytic Abuse is part of the subgroup of Sedative, Hypnotic and Anxiolytic Use Disorders.

- Sedative, Hypnotic and Anxiolytic include the Benzodiazepines, Carbamates and Barbiturates, comprising all sleeping medications and all anti-anxiety drugs apart from the non-Benzodiazepine Anxiolytics.

**Degree of Impairment**

<table>
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<th>Suggested Course of Action</th>
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<td>Medical Attention</td>
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<td>Mild</td>
<td>Therapy/Counseling</td>
<td>Natural Substance</td>
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<td>Support Group</td>
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<td>Special Needs</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Change of Location</td>
<td>Warning</td>
</tr>
</tbody>
</table>
|                       | Time off                  | Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

- **Always rule out** General Medical Conditions
- **Always rule out** Substance Related Disorders

Sedative, Hypnotic and Anxiolytic Dependence
Sedative, Hypnotic and Anxiolytic Withdrawal
Sedative, Hypnotic and Anxiolytic Intoxication
Sedative, Hypnotic and Anxiolytic Intoxication Delirium
Sedative, Hypnotic and Anxiolytic Withdrawal Delirium
Sedative, Hypnotic and Anxiolytic Induced Mood
Sedative, Hypnotic and Anxiolytic-Induced Withdrawal Delirium Generalized Anxiety
Sedative, Hypnotic and Anxiolytic-Induced Persisting Dementia
Sedative, Hypnotic and Anxiolytic-Induced Persisting Amnestic
Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Delusions
Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Hallucinations
Sedative, Hypnotic and Anxiolytic-Induced Sleep Disorder
Sedative, Hypnotic and Anxiolytic Induced Sexual Dysfunction
Sedative, Hypnotic and Anxiolytic Induced Generalized Anxiety Disorder
Internet Resources
http://www.emedicine.com/med/topic3119.htm
http://www.psyweb.com/Mdisord/jsp/subsd.jsp
http://www.xtramsn.co.nz/health/0(Pg. 320)8252-1941378,00.html
http://www.robertperkinson.com/the-drugs.htm
SEDATIVE, HYPNOTIC AND ANXIOLYTIC DEPENDENCE

**Behavioral Presentation**

- Over one twelve-month period Sedative, Hypnotic and Anxiolytic intake causes clinical distress and impairment.
- *Three or more of the following* within a twelve-month period: 1) more Sedative, Hypnotic and Anxiolytic is needed for the same effect, or 2) the same amount has less effect; 3) duration of use is greater over time; 4) experiences effects of withdrawal syndrome including more use to avoid withdrawal; 5) tries to control use; 6) spends a lot of time looking for using and recovering from the effects of Sedative, Hypnotic and Anxiolytic; 7) effects work, social and leisure functioning; 8) continues to use a Sedative, Hypnotic and Anxiolytic in spite of its negative physical and psychological effects.

**Specifiers, Codes and Comments**

- With Physiological Dependence – evidence of tolerance or withdrawal.
- Without Physiological Dependence – no evidence of tolerance or withdrawal.
- Early Full Remission – for a period of one to twelve months does not meet criteria for Abuse or Dependence.
- Early Partial Remission – for a period of one to twelve months meets criteria for Abuse, but not the full criteria for Dependence.
- Sustained Full Remission – for twelve months or longer does not meet criteria for Abuse or Dependence.
- Sustained Partial Remission – for twelve months or longer does not meet criteria for Dependence, but one or more of the criteria for Abuse and Dependence have been met.
- In a Controlled Environment – is in a controlled environment–hospital or inpatient clinic.

Sedative, Hypnotic and Anxiolytic Dependence is part of the subgroup of Sedative, Hypnotic and Anxiolytic Use Disorders.

**Degree of Impairment**

<table>
<thead>
<tr>
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<th>Psychopharmacology</th>
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<td>Medical Attention</td>
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<td>Therapy/Counseling</td>
<td>Natural Substance</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
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<tr>
<td>Moderate</td>
<td>Special Needs</td>
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<tr>
<td>Severe</td>
<td>Change of Location</td>
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</tr>
<tr>
<td>Moderate to Severe</td>
<td>Time off</td>
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</tbody>
</table>

**Alternate Diagnostic Presentation:**

*Always rule out* General Medical Conditions

*Always rule out* Substance Related Disorders

- Sedative, Hypnotic and Anxiolytic Abuse
- Sedative, Hypnotic and Anxiolytic Withdrawal
- Sedative, Hypnotic and Anxiolytic Intoxication
- Sedative, Hypnotic and Anxiolytic Intoxication Delirium
- Sedative, Hypnotic and Anxiolytic Withdrawal Delirium
Sedative, Hypnotic and Anxiolytic Induced Mood
Sedative, Hypnotic and Anxiolytic-Induced Withdrawal Delirium Generalized Anxiety
Sedative, Hypnotic and Anxiolytic-Induced Persisting Dementia
Sedative, Hypnotic and Anxiolytic-Induced Persisting Amnestic
Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Delusions
Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Hallucinations
Sedative, Hypnotic and Anxiolytic-Induced Sleep Disorder
Sedative, Hypnotic and Anxiolytic Induced Sexual Dysfunction
Sedative, Hypnotic and Anxiolytic Induced Generalized Anxiety Disorder

Internet Resources
http://www.merck.com/mrkshared/mmanual/section15/chapter195/195d.jsp
http://health.yahoo.com/health/centers/addiction/96407691.html
http://www.csusm.edu/DandB/Sedatives.html
http://www.kfshrc.edu.sa/annals/145/93210.html
SEDATIVE, HYPNOTIC AND ANXIOLYTIC INTOXICATION

Code Number: 292.89  
Category: Substance-Related

Behavioral Presentation

- Recent intake of Sedative, Hypnotic, or Anxiolytic causing maladaptive behavior and psychological effects including inappropriate sexuality or aggression, lability of mood, impaired judgment, impaired work, or social functioning.
- *One or more of the following* occur shortly after consumption: 1) slurred speech; 2) poor coordination; 3) unstable walking; 4) involuntary rhythmic eye movement; 5) impaired attention or memory; 6) stupor or memory loss.

Specifiers, Codes and Comments

- Sedative, Hypnotic and Anxiolytic Intoxication is part of the subgroup of Sedative, Hypnotic and Anxiolytic-Induced Disorders.
- Sedative, Hypnotic and Anxiolytic include the Benzodiazepines, Carbamates, and Barbiturates, comprising all sleeping medications and all anti-anxiety drugs apart from the non-Benzodiazepine Anxiolytics.
- From Latin – *intoxicare*, to poison, + *toxicum*, poison + -ation, indicating a process or condition.

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Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions
*Always rule out* Substance Related Disorders

- Sedative, Hypnotic and Anxiolytic Abuse
- Sedative, Hypnotic and Anxiolytic Dependence
- Sedative, Hypnotic and Anxiolytic Withdrawal
- Sedative, Hypnotic and Anxiolytic Intoxication Delirium
- Sedative, Hypnotic and Anxiolytic Withdrawal Delirium
- Sedative, Hypnotic and Anxiolytic Induced Mood
- Sedative, Hypnotic and Anxiolytic-Induced Withdrawal Delirium Generalized Anxiety
- Sedative, Hypnotic and Anxiolytic-Induced Persisting Dementia
- Sedative, Hypnotic and Anxiolytic-Induced Persisting Amnestic
- Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Delusions
- Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Hallucinations
- Sedative, Hypnotic and Anxiolytic-Induced Sleep Disorder
- Sedative, Hypnotic and Anxiolytic Induced Sexual Dysfunction
- Sedative, Hypnotic and Anxiolytic Induced Generalized Anxiety Disorder
Internet Resources
http://www.behavenet.com/capsules/disorders/shaintoxication.htm
http://www.benzo.org.uk/vot2.htm
http://www.beroendesidan.nu/citatb.htm
http://www.aafp.org/afp/20000401/2121.html
SEDATIVE, HYPNOTIC AND ANXIOLYTIC WITHDRAWAL

Code Number: 292.0  
Category: Substance-Related

Behavioral Presentation

- Stops or reduces sedative, hypnotic, and anxiolytic intake suddenly after long-term use. Affects work, social, leisure functioning.
- Two or more of the following within two hours to several days: 1) sweating 2) rapid heartbeat; 3) hand tremors; 4) sleeplessness; 5) nausea or vomiting; 6) short-term hallucinations or illusions; 7) heightened psychomotor activity; 8) anxiety; 9) grand mal seizures.

Specifiers, Codes and Comments

- With Perceptual Disturbances – auditory, visual illusions; tactile, auditory hallucinations with intact insight (the individual recognizes that the symptoms are not real).
- Sedative, Hypnotic and Anxiolytic include the Benzodiazepines, Carbamates, and Barbiturates, comprising all sleeping medications and all anti-anxiety drugs apart from the non-Benzodiazepine Anxiolytics.

Degree of Impairment  

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Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Sedative, Hypnotic and Anxiolytic Dependence
Sedative, Hypnotic and Anxiolytic Withdrawal
Sedative, Hypnotic and Anxiolytic Intoxication
Sedative, Hypnotic and Anxiolytic Intoxication Delirium
Sedative, Hypnotic and Anxiolytic Withdrawal Delirium
Sedative, Hypnotic and Anxiolytic Induced Mood
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Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Delusions
Sedative, Hypnotic and Anxiolytic-Induced Psychotic Disorder with Hallucinations
Sedative, Hypnotic and Anxiolytic-Induced Sleep Disorder
Sedative, Hypnotic and Anxiolytic Induced Sexual Dysfunction
Sedative, Hypnotic and Anxiolytic Induced Generalized Anxiety Disorder

Internet Resources
http://www.benzo.org.uk/breggin3.htm
SELECTIVE MUTISM

Code Number: 313.23  Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- Although the individual is able to speak, he or she remains mute in social environments such as school, church, or gatherings.
- Interferes with education, occupational achievement, social communication.
- One month or more not including the first month of school.
- Not caused by unfamiliarity or discomfort with spoken language or dialect.

Specifiers, Codes and Comments
- Selective Mutism is part of a subgroup of Other Disorders of Infancy, Childhood or Adolescence.
- Selective Mutism was formerly known as Elective Mutism
- Studies suggest that approximately less than 1.% of those seen in mental settings may suffer from Selective Mutism.
- From Latin – mutus, dumb.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Communication Disorder
Expressive Language Disorder
Mental Retardation
Mixed Receptive-Expressive Language
Pervasive Developmental
Phonological
Psychotic Disorder
Schizoid Personality
Social Phobia

Internet Resources
http://www.anxietynetwork.com/spsm.html
http://www.aboutourkids.org/aboutour/articles/about_mutism.html
http://www.isn.net/~jypsy/smutism.htm
SEPARATION ANXIETY

Code Number: 309.21  
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

Three or more of the following persist or occur in excess of what would be expected: 1) distress anticipating or experiencing separation from home or parents; 2) worry about loss or harm to parents; 3) worry about separation from parent as a result of a serious event, i.e., kidnapping, being lost, abandoned; 4) reluctance or refusal to leave due to fears of separation, i.e., school, camp, vacation, outing; 5) fear of being alone at home without parents or adults; 6) refusal or reluctance to sleep away from home without parents; 7) nightmares about separation; 8) physical symptoms, i.e, abdominal pain, nausea, vomiting, headache.

Lasts four weeks or more before the age of 18.

Specifiers, Codes and Comments

Early Onset – problem begins before age 6.
Separation Anxiety is part of a subgroup of Other Disorders of Infancy, Childhood or Adolescence.
Studies suggest that approximately 4% of all children and adolescents may suffer from Separation Anxiety Disorders.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
  - Moderate
  - Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Agoraphobia without History of Panic Disorder
Conduct Disorder
Depressive Disorder
Generalized Anxiety Disorder
Oppositional Defiant Disorder
Panic Disorder with Agoraphobia
Panic Disorder without Agoraphobia
Pervasive Developmental Disorder
Psychotic Disorder
Schizoid Personality
Social Phobia
Mood Disorder

**Internet Resources**
http://www.mentalhealth.com/dis/p20-ch03.html
http://kidshealth.org/parent/emotions/behavior/separation_anxiety.html
http://www.klis.com/chandler/pamphlet/panic/panicpamphlet.htm
http://www.baltimorepsych.com/separation_anxiety.htm
SEXUAL ABUSE OF ADULT

Code Number: V65.2

Category: Other Conditions That May Be a Focus of Clinical Attention

Behavioral Presentation

Problems relating to the sexual abuse of an adult: rape, sexual harassment, sexual coercion, etc.

Specifiers, Codes and Comments

- If the clinical attention is focused on the perpetrator and the abuse is by the partner use (Code – V61.12).
- If the clinical attention is focused on the perpetrator and the abuse is by someone other than the partner (Code – V62.83).
- If the clinical attention is focused on the victim (Code – 995.81).

Degree of Impairment

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</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources

http://ajp.psychiatryonline.org/cgi/content/abstract/160/2/369
http://open-mind.org/Abuse.htm
http://www.ncptsd.org/facts/specific/fs_male_sexual_assault.html
http://www.medicineau.net.au/clinical/psychiatry/SexualAbuse.html
SEXUAL ABUSE OF CHILD

**Code Number:** V61.21  
**Category:** Other Conditions That May Be a Focus of Clinical Attention

**Behavioral Presentation**  
Problems relating to the sexual abuse of a child.

**Specifiers, Codes and Comments**  
If the clinical attention is focused on the victim use (Code – 995.53)

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</table>

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

**Internet Resources**
http://www.ncptsd.org/facts/specific/fs_child_sexual_abuse.html  
http://open-mind.org/Abuse.htm  
http://www.cybertipline.com/
SEXUAL AROUSAL

Code Number: 302.72
Category: Sexual and Gender Identity

Behavioral Presentation

Unable to become vaginally lubricated enough to complete a sexual act.
Causes marked distress and interpersonal problems.

Specifiers, Codes and Comments

Lifelong Type – has existed for the individual’s entire sexual life.
Acquired Type – exists for periods of time.
Generalized Type – exists with any partner or sexual activity.
Situational Type – exists only with certain partners or situations.
Due to Psychological Factors – only psychological issues.
Due to Combined Factors – both psychological and physical issues.

Sexual Arousal Desire Disorder are part of the Sexual Arousal Disorders which are a subgroup of Sexual Dysfunctions.

Studies suggest that approximately 33% of all women may have this Sexual Arousal Disorder.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources

http://altmedicine.about.com/cs/womenshealth/a/sexualdys_women.htm
http://cms.psychologytoday.com/conditions/sexarousal.html
http://www.psychnet-uk.com/dsm_iv/female_sexual_arousal_disorder.htm
http://www.healthatoz.com/healthatoz/Atoz/ency/female_sexual_arousal_disorder_.jsp
SEXUAL AVersion

Code Number: 302.79 Category: Sexual and Gender Identity

Behavioral Presentation
- Complete avoidance and dislike of nearly all genital contact with a sexual partner.
- Fantasy about sexual activity is predominately void.
- Causes marked distress and interpersonal problems.

Specifiers, Codes and Comments
- Lifelong Type – has existed for the individual’s entire sexual life.
- Acquired Type – exists for periods of time.
- Generalized Type – exists with any partner or sexual activity.
- Situational Type – exists only with certain partners or situations.
- Due to Psychological Factors – only psychological issues.
- Due to Combined Factors – both psychological and physical issues.

Sexual Aversion Disorders are part of the Sexual Desire Disorders which are a subgroup of Sexual Dysfunctions.

From Latin – aversus, turned away or hostile; avertere, to turn, vertere to turn.

Degree of Impairment Suggested Course of Action Psychopharmacology

| Very Mild | Medical Attention | Medications |
| Mild | Therapy/Counseling | Natural Substance |
| Mild to Moderate | Support Group | |
| Moderate | Special Needs | None Suggested |
| Moderate to Severe | Change of Location | Warning: Medications and natural substances should be used with a doctor’s approval. |
| Severe | Time off | |

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Major Depressive Disorder
Female Orgasmic Disorder
Female Sexual Arousal Disorder
Hypoactive Sexual Desire Disorder
Obsessive-Compulsive Disorder
Somatization Disorder
Specific Phobia

Internet Resources
http://www.marriagebuilders.com/graphic/mbi5047_qa.html
http://allpsych.com/disorders/sexual/sexualaversion.html
http://www.pureintimacy.org/cs/couples/a0000095.cfin
SEXUAL MASOCHISM

Code Number: 302.83  
Category: Sexual and Gender Identity

Behavioral Presentation

- Strong sexual impulse, fantasy, or behavior involving real or simulated acts of being humiliated, beaten, bound, or made to suffer.
- The behavior takes place for six months or more.

Specifiers, Codes and Comments

- Sexual Masochism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular paraphilia.
- It is estimated that 50% of those seen for a paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.
- Named after Leopold von Sacher-Masoch (1836–95) who wrote about it in his novel Venus in Pelz (1870).

Degree of Impairment  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Degree of Impairment  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Dementia  
Exhibitionism  
Fetishism  
Frotterism  
Gender Identity Disorder  
Manic Episode  
Mental Retardation  
Schizoid Personality  
Transvestic Fetishism  
Voyeurism

Internet Resources
http://www.psychnet-uk.com/dsm_iv/sexual_masochism_disorder.htm  
http://allpsych.com/disorders/paraphilias/masochism.html  
http://health.yahoo.com/health/centers/sexual_health/96409445  
http://www.merck.com/mmhe/sec07/ch104/ch104c.html
SEXUAL SADISM

Code Number: 302.84  
Category: Sexual and Gender Identity

Behavioral Presentation

- Strong sexual impulse, fantasy, or behavior causing real or simulated acts of others being humiliated, beaten, bound, or made to suffer.
- The behavior takes place for six months or more.
- Impairs work, social or personal functioning.

Specifiers, Codes and Comments

- Sexual Sadism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular paraphilia.
- It is estimated that 50% of those seen for a paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.
- “Sadism” comes from the name of a French author, who lived from 1740 to 1814: Donatien-Alphonse-Francois de Sade, better known as the Marquis de Sade.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Dementia
Exhibitionism
Fetishism
Frotterism
Gender Identity Disorder
Manic Episode
Sexual Masochism
Mental Retardation
Schizophrenia
Transvestic Fetishism
Voyeurism

Internet Resources
http://www.psychnet-uk.com/dsm_iv/sexual_sadism_disorder.htm
http://faculty.ncwc.edu/toconnor/428/428lect13.htm
http://www.psychdirect.com/forensic/Criminology/para/sadism.htm
**SHARED PSYCHOTIC**

**Code Number:** 297.3  
**Category:** *Schizophrenia and Other Psychotic Disorder*

**Behavioral Presentation**
- Individual acquires Delusion(s) (Pg. 128) as a result of someone who has a delusion.
- Delusion is similar to the delusion of the primary.

**Specifiers, Codes and Comments**
- Shared Psychotic Disorder is also referred to as, *Folie a Deux*, Induced Delusional Disorder, or Shared Paranoid Disorder.

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**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- ☒ Moderate to Severe
- Severe

**Suggested Course of Action**
- ☒ Medical Attention
- ☒ Therapy/Counseling
- ☒ Support Group
- ☒ Special Needs
- Change of Location
- ☒ Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning**: Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

**Internet Resources**
- [http://www.emedicine.com/med/topic3352.htm](http://www.emedicine.com/med/topic3352.htm)  
- [http://www.mentalhealth.com/dis/p20-ps06.html](http://www.mentalhealth.com/dis/p20-ps06.html)  
- [http://www.psychcentral.com/disorders/sx54.htm](http://www.psychcentral.com/disorders/sx54.htm)
## SIBLING RELATIONAL PROBLEM

**Code Number:** V61.8  
**Category:** Other Conditions That May Be a Focus of Clinical Attention

### Behavioral Presentation
Problems associated with symptoms or negative effects on the functioning between siblings.

### Specifiers, Codes and Comments

<table>
<thead>
<tr>
<th>Degree of Impairment</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Mild</td>
<td>Medical Attention</td>
<td>Medications</td>
</tr>
<tr>
<td>Mild</td>
<td></td>
<td>Natural Substance</td>
</tr>
<tr>
<td>☒ Mild to Moderate</td>
<td>☒ Therapy/Counseling</td>
<td>☒ None Suggested</td>
</tr>
<tr>
<td>Moderate</td>
<td>☒ Support Group</td>
<td>Warning: Medications and natural substances should be used with a doctor’s approval.</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
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</tr>
<tr>
<td>Severe</td>
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<td></td>
</tr>
</tbody>
</table>

### Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

### Internet Resources
- [healthinmind.com/english/relatpr.htm](http://healthinmind.com/english/relatpr.htm)  
- [user.mc.net/~mcc/page13.html](http://user.mc.net/~mcc/page13.html)  
- [www.sengifted.org/articles_counseling/Webb_MisdiagnosisAndDualDiagnosisOfGiftedChildren.shtml](http://www.sengifted.org/articles_counseling/Webb_MisdiagnosisAndDualDiagnosisOfGiftedChildren.shtml)
SLEEP TERROR

Code Number: 307.46

Behavioral Presentation
- Walks up screaming in panic.
- Marked appearance of fear with rapid breathing, rapid heartbeat, sweating.
- Unable to respond to others providing emotional solace and comfort.
- No recall of dream. Later has no recall of the episode.

Specifiers, Codes and Comments
- Sleep Terror Disorder is part of a subgroup of Parasomnias.
- Sleep Terror Disorder are also referred to as Night Terrors Disorders, Pavor Nocturnus, or Pavor Diurnus if the problem occurs during the day.
- Occurs on numerous occasions.
- Usually wakes up during the first third of sleep pattern.
- Studies suggest that approximately 1% to 6% of children may suffer from this problem.
- Studies suggest that approximately 1% of adults may suffer from this problem.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Degree of Impairment

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Breathing-Related Sleep Disorder
Narcolepsy
Nightmare Disorder
Panic Disorder
Sleepwalking Disorder

Internet Resources
http://www.psychnet-uk.com/dsm_iv/sleep_terrors_disorder.htm
http://www.nightterrors.org/
http://psychcentral.com/disorders/sx91.htm
http://www.macalester.edu/~psych/whathap/UBNRp/nightmares/zSleep_Terror_Disorder.html
SLEEPWALKING

Code Number: 307.46

Category: Sleep

Behavioral Presentation

Walks while sleeping on many occasions.
Difficult to wake, stares blankly, does not respond to communication.
No memory of episode.
Impairs work, social and personal functioning.

Specifiers, Codes and Comments

Sleepwalking is part of a subgroup of Parasomnias
Usually occurs during the first third of sleep pattern.
Individual is unimpaired after awakening.
Somnambulism means sleepwalking.
Studies suggest that approximately 10% to 30% of children may suffer from Sleepwalking Disorder.
Studies suggest that approximately 2% to 3% of children may have frequent Sleepwalking Disorder episodes.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Breathing-Related Sleep Disorder
Dissociative Fugue
Malingering, Sleep Terror Disorder

Internet Resources

http://www.psychnet-uk.com/dsm_iv/sleepwalking_disorder.htm
http://psychcentral.com/disorders/sx93.htm
http://www.behavenet.com/capsules/disorders/sleepwalkdis.htm
SOCIAL PHOBIA

Code Number: 300.23  
Category: Anxiety

Behavioral Presentation
- Fears social or performance situations involving strangers or being watched by others.
- Individual knows the feelings are unreasonable.
- Fears showing anxiety, which may be a cued or situationally predisposed Panic Attack, and behaving in an embarrassing, humiliating way.
- Individual avoids stimulus or endures the experience with great anxiety and is markedly distressed over the phobia or the phobia markedly interferes with routines, social or personal functioning.
- Under 18 must experience problem for six months or more.

Specifiers, Codes and Comments
- Generalized – fears most social situations.
- Social Phobia is also known as Social Anxiety Disorder.
- Children do not receive this diagnosis unless they are able to have social relationships.
- Anxiety occurs with both adults and peers.
- Behavior occurs in the form of clinging, withdrawing, freezing, crying, etc.
- Studies suggest that approximately 10% to 20% of the general population may suffer from Social Phobias.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Anorexia
Avoidant Personality
Generalized Anxiety Disorder
Mood Disorder
Panic Disorder With Agoraphobia
Pervasive Developmental
Schizoid Personality
Separation Anxiety Disorder
Specific Phobia

Internet Resources
http://www.socialphobia.org/
http://www.mentalhealth.com/dis/p20-an03.html
http://kidshealth.org/teen/your_mind/mental_health/social_phobia.html
http://www.nimh.nih.gov/HealthInformation/socialphobiamenu.cfm
SOMATIZATION

Code Number: 300.81  
Category: Somatoform

Behavioral Presentation

Before the age of 30 the individual complains of multiple pain symptoms.

Four or more of the following, at the same time, in four separate sites: 1) four general body pain symptoms; 2) two gastrointestinal symptoms; 3) one sexual symptom; 4) one pseudoneurological symptom.

For each of the symptoms at least one of the following must be met: 1) physical or laboratory results show no medical problems; 2) there is no history of a medical condition relating to the complaints.

Believes the physiological problems are real.

Specifiers, Codes and Comments

Somatoform Disorder was previously known as Hysteria or Briquet’s Syndrome.

Studies suggest that approximately 0.2% to 2% of women and less than 0.2% of men may suffer from Somatization Disorder.

From – Greek, soma body + -izein, cause to become or to resemble.

Degree of Impairment  

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

☒ Medical Attention
☒ Therapy/Counseling
☒ Support Group
☒ Special Needs
Change of Location
Time off

Psychopharmacology

☒ Medications
☒ Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Antisocial Personality
Generalized Anxiety Disorder
Borderline Personality
Conversion Disorder
Dissociative Disorder
Factitious Disorder
Histrionic Personality
Hypochondriasis Disorder
Malingering
Mood Disorder
Pain Disorder
Panic Disorder
Schizophrenia
Sexual Dysfunction
Somatoform Disorder

Internet Resources

http://www.cfsdoc.org/somat.htm
SPECIFIC PHOBIA

**Code Number:** 300.29  
**Category:** Anxiety

**Behavioral Presentation**
- Strong, persistent fear that is excessive, unreasonable, out of proportion. The individual knows the feelings are unreasonable.
- Set off (cued) by a specific object or situation that is persistent or anticipated.
- Individual avoids stimulus or endures the experience with great anxiety.
- Under 18 must experience problem for six months or more.

**Specifiers, Codes and Comments**

- **Situational Type** – airplane, closed in.
- **Natural Environment Type** – heights, thunderstorms.
- **Blood-Injection-Injury Type**.
- **Animal Type** – spiders, clowns, monkeys.
- **Other Type** – situations leading to illness, choking, vomiting.

Specific Phobia was formerly known as Simple Phobia.

Studies suggest that approximately 4% to 8.8% of the general population may suffer from Specific Phobia with a lifetime rate from approximately 7.2% to 11.3%.

**Degree of Impairment**
- Very Mild
- Mild
- **Mild to Moderate**
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- **Medications**
- **Natural Substance**
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Hypochondriasis Disorder
- Obsessive-Compulsive Disorder
- Panic Disorder with Agoraphobia
- Posttraumatic Stress Disorder
- Psychotic Disorder
- Schizoid Personality
- Separation Anxiety Disorder
- Social Phobia Disorder

**Internet Resources**
- [http://www.adda.org/AnxietyDisorderInfor/SpecificPhobia.cfm](http://www.adda.org/AnxietyDisorderInfor/SpecificPhobia.cfm)
http://www.psychnet-uk.com/dsm_iv/specific_phobias.htm
STEREOTYPIC MOVEMENT

Code Number: 307.3
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
- Motor behavior appears driven, repetitive and nonfunctional, i.e., biting or hitting, picking of skin or body openings.
- Interferes with normal activities or causes physical injury that may require medical treatment.

Specifiers, Codes and Comments
- With Self-Injurious Behavior – results in self injurious activity.
- Stereotypic Movement Disorder is part of a subgroup of Other Disorders of Infancy, Childhood or Adolescence.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Factitious Disorder
Mental Retardation
Obsessive-Compulsive Disorder
Personality
Pervasive Developmental Disorder
Psychotic Disorder
Tardive Dyskinesia
Trichotillomania.

Internet Resources
http://www.psychcentral.com/disorders/sx79.htm
http://www.drkoop.com/ency/article/001548.htm
http://www.emedicine.com/ped/topic909.htm
http://www.ehendrick.org/healthy/001548.htm
STUTTERING

Code Number: 307.0  
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation

- Speech pattern is interrupted by abnormal fluency and patterning of speech as may be appropriate for the individual’s age.
- One or more of the following: 1) repetitions of sounds and syllables; 2) prolongation of sounds; 3) interjections; 4) monosyllabic repetitions; 5) words spoken with excessive physical tension; 6) substitution for words that are hard to pronounce; 7) pauses within words; 8) blocking speech that is audible or silent.
- Education, occupational achievement or social communication is interrupted.

Specifiers, Codes and Comments

- Stuttering is part of a subgroup of Communication Disorders.
- Code all sensory deficits or neurological conditions on Axis III.
- Mental retardation, environmental deprivation, speech-motor, or sensory deficit may worsen the individual’s problem.
- Developmental language delays are more common than acquired language delays.
- Studies suggest that approximately 1% of prepubescent children and 0.8% of adolescents may suffer from Stuttering Disorder.

Degree of Impairment

<table>
<thead>
<tr>
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<td>- Natural Substance</td>
</tr>
<tr>
<td>Mild</td>
<td>- Support Group</td>
<td>- None Suggested</td>
</tr>
<tr>
<td>Mild to Moderate</td>
<td>- Special Needs</td>
<td>- Warning: Medications</td>
</tr>
<tr>
<td>Moderate</td>
<td>- Change of Location</td>
<td>and natural substances</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>- Time off</td>
<td>should be used with a</td>
</tr>
<tr>
<td>Severe</td>
<td></td>
<td>doctor’s approval.</td>
</tr>
</tbody>
</table>

Alternate Diagnostic Presentation

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Internet Resources

http://www.stuttering.net/  
http://www.prevent-stuttering.com/  
http://www.asha.org/public/speech/disorders/stuttering.htm  
http://kidshealth.org/kid/health_problems/sight/stuttering.html
SUBSTANCE-INDUCED DELIRIUM

Code Number: None  Category: Delirium, Dementia, Amnestic and Other Cognitive Behavior Presentation

Behavioral Presentation
- Reduced level of consciousness and difficulty focusing, shifting or sustaining attention.
- Dementia (Pg. 156) does not explain the problem.
- Rapid development over hours to days with a variation in deficit during the day.
- Impairs work or social functioning.

Specifiers, Codes and Comments
- Use the condition outline of Delirium.
- Substance-Induced Delirium should be used when the cognitive presentation is beyond what would be expected in Substance Intoxication.
- Code with the specific substances cause the Delirium.
- Substance-Induced Delirium is used when the presentation is caused by medication.
- Include the name of the Specific General Medical Condition in Axis I and III.
- If Vascular Dementia is preexisting, indicate Delirium coded as (290.41.) or Vascular Dementia With Delirium.
- From Latin – delirium, insanity; delirus, insane; delirare, to turn aside; de from + lira, a furrow.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested
- Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Acute Stress Disorder
Generalized Anxiety Disorder
Brief Psychotic Disorder
Delirium Due to Multiple Etiologies
Factitious
Malingering
Mood Disorders
Psychotic Disorder
Schizoid Personality
Schizoaffective Disorder
Substance Intoxication Delirium
Substance Withdrawal Delirium
Internet Resources
http://www.wrongdiagnosis.com/sym/delirium.htm
http://www.adroga.casadia.org/abuse/abuse11_i.htm
http://www.twilightbridge.com/psychiatryproper/diagnosticcriter/DSMIV/dsmschizophrenia.htm
http://www.clevelandclinicmeded.com/diseasemanagement/psychiatry/delirium/delirium.htm
SUBSTANCE-INDUCED PERSISTING AMNESTIC

Code Number: 294.0
Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation

► Inability to learn new information or remember previously learned information as a result of taking a substance(s).
► Does not occur during Delirium or Dementia.
► Physical exam, history and laboratory findings support the use of a substance or medications.

Specifiers, Codes and Comments

Identify the substance(s) using the individual codes.

Degree of Impairment

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<td>☒ Natural Substance</td>
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<tr>
<td>Mild to Moderate</td>
<td>Support Group</td>
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</tr>
<tr>
<td>Moderate</td>
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<tr>
<td>Moderate to Severe</td>
<td>☒ Change of Location</td>
<td></td>
</tr>
<tr>
<td>☒ Severe</td>
<td>☒ Time off</td>
<td></td>
</tr>
</tbody>
</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Age-Related Cognitive Decline
Amnestic Disorder Due to a General Medical Condition
Delirium
Dementia
Dissociative Disorder
Factitious Disorder
General Medical Condition
Malingering
Substance Withdrawal
Substance-Induced Persisting Amnestic Disorder
Substance-Intoxication

Internet Resources

http://www.casafuturatech.com/
http://telosnet.com/dmdodge/veils/
http://www.mnsu.edu/comdis/kuster/
http://members.tripod.com/caroline_bowen/stuttering.htm
SUBSTANCE-INDUCED PERSISTING DEMENTIA

Code Number: None
Category: Delirium, Dementia, Amnestic and Other Cognitive

Behavioral Presentation
See Dementia (Pg. 156).
Deficits of thinking caused from substances, including medication, evidenced by inability to learn new information or remember previously learned information.
One or more of the following of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments
Without Behavioral Disturbance—no behavioral disturbance (Code – 294.10).
With Behavioral Disturbance—behavioral disturbance (Code – 294.11).
Use specific substance codes.
Refer to Dementia (Pg. 156).
Decline in mental functioning is gradual and worsens over time.
Not due to other Dementia (Pg. 156) causes.
Symptoms do not exist solely during Delirium, Substance Intoxication, or Substance Withdrawal.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Internet Resources
http://healthinmind.com/english/subinddem.htm
http://www.ny-psychotherapy.com/dsm.html
http://www.behavenet.com/capsules/disorders/substinddem.htm
http://mysite.verizon.net/res7oqx1/id6.html
TOURETTE’S

**Code Number:** 307.23  
**Category:** Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

**Behavioral Presentation**
- One or more vocal tics and multiple motor tics that begin before age 18.
- For one or more years, the individual tics each day, almost every day, or at intervals.
- Tics never stop longer than three months.

**Specifiers, Codes and Comments**
- **Add Coprolalia** – if obsessive, obscene utterances are part of the Tourette’s.
- **Add Copropraxia** – if compulsive or repetitive, obscene gestures are part of the Tourette's disorder.
- Tourette’s is part of a subgroup of Tic Disorders.
- A tic is a motor movement or vocalization that is nonrhythmic, rapid, repeated, stereotyped, or sudden.
- Studies suggest that approximately 5 to 30 per 10,000 children and 1 to 2 per 10,000 adults may suffer from Tourette’s.
- Giles de la Tourette’s Syndrome is the complete name for Tourette’s.

**Degree of Impairment**
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

- Athetoid Movements
- Chorea, Chronic Motor and Vocal Tic Disorder
- Dystonic Movements
- Hemiballistic Movement
- Myoclonic Movements
- Pervasive Development Disorder
- Schizoid Personality Disorder
- Stereotypic Movement Disorder
- Transient Tic Disorder

**Internet Resources**
- http://www.tourettes.com/
- http://www.tourettes-disorder.com/
- http://www.tourette-syndrome.net/
http://www.findinfo.com/tourettes.htm
TRANSIENT TIC

Code Number: 307.21
Category: Disorders Usually First Diagnosis in Infancy, Childhood or Adolescence

Behavioral Presentation
One or both vocal tics and multiple motor tics that begin before age 18.
Tics never stop longer than three months.

Specifiers, Codes and Comments

Single Episode

Recurrent
Transient Tic Disorder is part of a subgroup of Tic Disorders.
A tic is a motor movement or vocalization that is nonrhythmic, rapid, repeated, stereotyped, or sudden.
Studies suggest that approximately 5% to 24% of all school-age children may have had Transient Tic Disorder.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Degree of Impairment

Very Mild
Mild
Mild to Moderate
Moderate
Moderate to Severe
Severe

Suggested Course of Action

Medical Attention
Therapy/Counseling
Support Group
Special Needs
Change of Location
Time off

Psychopharmacology

Medications
Natural Substance
None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Athetoid Movements
Chorea
Chronic Motor and Vocal Tic Disorder
Dystonic Movements
Hemiballismic Movement
Myoclonic Movements
Pervasive Development Disorder
Schizoid Personality Disorder
Stereotypic Movement Disorder
Tourette’s

Internet Resources
http://www.psychnet-uk.com/dsm_iv/transient_tic_disorder.htm
http://health.discovery.com/encyclopedias/1809.html
http://www.drkoop.com/ency/article/000747.htm
http://psychcentral.com/disorders/sx82.htm
TRANSVESTIC FETISHISM

Code Number: 302.3 Category: Sexual and Gender Identity

Behavioral Presentation

- Strong sexual impulse, fantasy or behavior focused on being interested in dressing in clothes of the opposite sex.
- The behavior takes place for six months or more.

Specifiers, Codes and Comments

- Transvestic Fetishism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular paraphilia.
- Transvestic Fetishism is also referred to as Fetishistic Transvestism.
- It is estimated that 50% of those seen for a paraphilia are married.
- Paraphilia means abnormal or unnatural attraction.
- From Latin – trans, across + vestire, to dress.

Degree of Impairment

- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action

- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology

- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

- Dementia
- Exhibitionism
- Fetishism
- Frotteruism
- Gender Identity Disorder
- Manic Episode
- Sexual Masochism
- Mental Retardation
- Schizophrenia
- Voyeurism

Internet Resources

http://allpsych.com/disorders/paraphilias/transvestite.html
http://www.psychnet-uk.com/dsm_iv/transvestic_fetishism.htm
http://www.psychdirect.com/forensic/Criminology/para/transfetishism.htm
http://www.umkc.edu/sites/hsw/issues/transves.html
TRICHOTILLOMANIA

Code Number: 312.39
Category: Impulse-Control

Behavioral Presentation
Individual pulls out hair from their head, eye brows, mustache, beard, arms, legs, or pubic area.

Specifiers, Codes and Comments
- The individual feels tension and emotion. Once the need to pull hair out has been fulfilled the individual feels pleasure, gratification and relief.
- Women tend to dominate this category.
- From Greek – trichos, of hair; thrix, hair + tillein, to pull + mania madness; frenzy to pull hair.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Anxiety Disorder
Factitious Disorder
Obsessive-Compulsive Disorder
Pica
Mood Disorder
Stereotypic Movement Disorder

Internet Resources
http://www.trich.org/
http://www.mhfa.org/infoctr/factsheets/92.cfm
http://kidshealth.org/teen/question/illness_infection/trichotillomania.html
http://www.vh.org/adult/patient/psychiatry/trichotillomania/
UNDIFFERENTIATED SOMATOFORM

**Code Number:** 300.82  
**Category:** Somatoform

**Behavioral Presentation**
- Has at least one or more physical complaints most commonly chronic tiredness, loss of appetite, gastrointestinal or urinary problems.
- *One or more of the following* must be met for each of the symptoms: 1) physical or laboratory results show no medical problems; 2) there is no history of a medical condition relating to the complaints.
- Condition has lasted six months or longer.

**Specifiers, Codes and Comments**
- From Greek – *soma*, body + Latin – *forma*, form.

**Degree of Impairment**  
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out General Medical Conditions*  
*Always rule out Substance Related Disorders*

Borderline Personality Disorder  
Conversion Disorder  
Disorder of Written Expression  
Factitious Disorder  
Generalized Anxiety Disorder  
Histrionic Personality Disorder  
Hypochondriasis Disorder  
Malingering  
Mood Disorder  
Pain Disorder  
Panic Disorder  
Somatization Disorder

**Internet Resources**
- [http://www.wrongdiagnosis.com/u/undifferentiated_somatoform_disorder/intro.htm](http://www.wrongdiagnosis.com/u/undifferentiated_somatoform_disorder/intro.htm)  
VAGINISMUS

Code Number: 306.51  
Category: Sexual and Gender Identity

Behavioral Presentation
- Recurrent or persistent involuntary spasm of the perineal muscles surrounding the vaginal muscle; spasms interfere with sexual intercourse.
- Problem is chronic and recurrent.
- Causes marked distress and interpersonal problems.

Specifiers, Codes and Comments
- Lifelong Type – exists for the individual’s entire sexual life.
- Acquired Type – exists for periods of time.
- Generalized Type – exists with any partner or sexual activity.
- Situational Type – exists only with certain partners or situations.
- Due to Psychological Factors – only psychological issues.
- Due to Combined Factors – both psychological and physical issues.

Vaginismus is part of the Sexual Pain Disorders which are a subgroup of Sexual Dysfunctions.

From Latin – vagina, a sheath + -ismus, indicating a state or condition.

Degree of Impairment
- Very Mild
- Mild
- Mild to Moderate
- Moderate
- Moderate to Severe
- Severe

Suggested Course of Action
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

Psychopharmacology
- Medications
- Natural Substance
- None Suggested

Warning: Medications and natural substances should be used with a doctor’s approval.

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Generalized Anxiety Disorder
Dyspareunia
Mood Disorder
Psychotic Disorder
Somatization Disorder.

Internet Resources
http://www.umkc.edu/sites/hsw/issues/vaginis.html
http://www.womentc.com/vaginismus.htm
http://www.psychnet-uk.com/dsm_iv/vaginismus_disorder.htm
VASCULAR DEMENTIA

Code Number: 290.4X          Category: Delirium, Dementia, Amnestic and Other Cognitive Presentation

Behavioral Presentation

- See Dementia (Pg. 156).
- Can not learn new information or can not recall previously learned information, this does not occur solely during delirium, and cerebral vascular disease is the probable cause of the deficits or by focal neurologic signs and symptoms, i.e., increased deep tendon reflexes, weakness in limbs, abnormal gait, extensor Babinski reflex.
- One or more of the following: 1) Aphasia; 2) Apraxia; 3) Agnosia; 4) impaired executive functioning.

Specifiers, Codes and Comments

- With Depressed Mood (Code – 290.43).
- With Delirium (Code – 290.41).
- Uncomplicated (Code – 290.40).
- With Behavioral Disturbance – behavioral disturbance (Code – 294.11).
- Cerebral Artery Occlusion.
- Only code when the depressive symptoms meet the full criteria for Major Depressive Episode.
- Decline in mental functioning is gradual and worsens over time.
- Not due to other Dementia causes.
- Symptoms due not exist solely during delirium.
- Code Cerebrovascular condition on Axis III.
- Vascular Dementia was formerly known as Multi-Infarct Dementia.
- Latin – dementare, to drive mad; from de from + mens mind + -ia, indicating a condition or quality.

<table>
<thead>
<tr>
<th>Degree of Impairment</th>
<th>Suggested Course of Action</th>
<th>Psychopharmacology</th>
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<tr>
<td>Very Mild</td>
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<td>Mild to Moderate</td>
<td>Support Group</td>
<td>None Suggested</td>
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<tr>
<td>Moderate</td>
<td>Special Needs</td>
<td>Warning: Medications and natural substances should be used with a doctor’s approval.</td>
</tr>
<tr>
<td>Moderate to Severe</td>
<td>Change of Location</td>
<td></td>
</tr>
<tr>
<td>Severe</td>
<td>Time off</td>
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</tr>
</tbody>
</table>

Alternate Diagnostic Presentation

Always rule out General Medical Conditions
Always rule out Substance Related Disorders

Cognitive Disorder
Delirium
Dementia of the Alzheimer’s Type
Dementia Due to Other General Medical Conditions
Factitious Disorder
Major Depressive Episode
Malingering
Mental Retardation
Schizophrenia
Substance Intoxication
Substance Withdrawal
Substance-Induced Dementia
VOYEURISM

**Code Number:** 302.82  
**Category:** Sexual and Gender Identity

**Behavioral Presentation**
- Strong sexual impulse, fantasy, or behavior involving viewing unsuspecting individual(s) in various states of undress or having sex.
- The behavior takes place for six months or more.

**Specifiers, Codes and Comments**
- Voyeurism is in a subgroup of Paraphilias.
- The individual’s primary sexual experience is maintained in the preferred activities associated with a particular Paraphilia.
- It is estimated that 50% of those seen for a Paraphilia are married.
- Paraphilia means abnormal or unnatural attraction. Voyeurism is also known as being a “Peeping Tom.”
- As legend has it, the label “Peeping Tom” originated when Lady Godiva rode through her town naked to protest taxes being imposed by her husband on the townspeople. All the townspeople were to close their shutters so they could not observe Lady Godiva’s naked body. One man, Tom, opened his shutters. Hence, “Peeping Tom”. Tom was reportedly blinded for his transgressions.
- From French – *voyeur*, one who observes or sees.

**Degree of Impairment**
- **Very Mild**
- **Mild**
- **Mild to Moderate**
- **Moderate**
- **Moderate to Severe**
- **Severe**

**Suggested Course of Action**
- Medical Attention
- Therapy/Counseling
- Support Group
- Special Needs
- Change of Location
- Time off

**Psychopharmacology**
- Medications
- Natural Substance
- None Suggested

**Warning:** Medications and natural substances should be used with a doctor’s approval.

**Alternate Diagnostic Presentation**

*Always rule out* General Medical Conditions  
*Always rule out* Substance Related Disorders

Dementia  
Exhibitionism  
Fetishism  
Frotterism  
Gender Identity Disorder  
Manic Episode  
Sexual Masochism  
Mental Retardation  
Schizophrenia  
Transvestic Fetishism.

**Internet Resources**
http://www.psychnet-uk.com/dsm_iv/voyerism_disorder.htm
http://www.bigeye.com/sexeducation/voyeurism.html
http://www.jahsonic.com/Voyeurism.html
Diagnostic Categories

General Characteristics
Identification of the presenting characteristics within the diagnostic category under investigation.

Disorders in this Category
Listing of all the specific disorders included in the book cross-referenced to each individual diagnosis.

Internet Resources
Internet Resources focusing on the diagnostic category under investigation.

Movie Suggestions
Lists of movies portraying pathologies of psychiatric diagnostic presentations in the identified category.

NOTE: Movies are an excellent vehicle for acquiring a visual and behavioral understanding of a wide variety of medical and psychiatric pathologies. Originally I planned to identify the specific diagnosis presented in each movie. However, after some consideration I elected to supply you with a list of movies without identifying the pathology. I would like to support you in taking the time to watch some of the movies within each diagnostic category. Use the movie presentations to learn how to identify each of the separate pathologies offered in the movies.

There is no question that some movies are more extensive and focused in their presentations of pathologies than other movies. While the Days of Wine and Roses and When a Man Loves a Woman offer an entire movie on the subject of Alcohol-Related Disorders, other movies such as The Upside of Anger and Pay It Forward are less extensive in their presentations of this disorder. Movies such as Girl Interrupted and many others offer multiple pathologies. Therefore, you will find these movies cross listed under each appropriate diagnostic category. There are some movies, such as The Sixth Sense (Factitious Disorder by Proxy) and Dirty Filthy Love (Trichotillomania) that present very short sections of the particular pathology under investigation. Sometimes these sections are as short as 15 to 30 seconds long. They are included because I believe they are strong examples of the pathologies under investigation.

You will notice that categories such as Substance-Related Disorders and Personality Disorders offer extensive lists of movies while other categories such as Eating Disorders offer a brief list of movies. I attempted to locate as many movies as possible for each category. However, clearly there are more movies about alcohol and drugs than some of the other categories.

Please do not limit yourself to my list. Go on a self-directed journey and attempt to identify pathologies in movies that are not in my list or additional pathologies which were not cross-listed under other categories.
Additional Disorders
The Index of Additional Disorders contains disorders, syndromes, and descriptors not currently offered in the Diagnostic and Statistical Manual of Mental Disorders, IV TR. The Additional Disorders are included within each individual general category. Where there is a subcategory within a disorder, each disorder is identified with the individual subcategory next to the presenting disorder. (Most Additional Disorders are directly quoted from Adam Colman’s (2001) *Oxford Reference Online, A Dictionary of Psychology* noted in this book’s reference page.)
Additional Codes

Additional Codes are mental disorders not included in the DSM-IV Classification, not appropriate or not available in the Not Otherwise Specified Classification, or there is not enough information to apply a specific psychiatric category in a classification.

Disorders in this Category
- Diagnosis or Condition Deferred on Axis I (Code – 799.9)
- Diagnosis Deferred on Axis II (Code – 799.9)
- No Diagnosis on Axis II (Code – V71.09)
- No Diagnosis or Condition on Axis I (Code – V71.09)
- Unspecified Mental Disorder (Code – 300.9)

Internet Resources
Check specific Internet Resources for information.

Movie Suggestions
- There are no specific movies offered for Additional Codes.
Adjustment Disorders

Adjustment Disorders consist of individuals with mental disorders who are having a difficult time adjusting to life situations. The adjustment problems exist to a degree that they develop clinically significant behavioral and emotional symptoms as a direct result of a psychosocial stressor. These difficulties are beyond what would be expected for a given situation. The adjustments may be related to new jobs, being fired, death, ending of a romantic relationship, business problems, natural disaster, inability to attain personal goals, ending of a friendship, relocation, etc.

Disorders in this Category
- Adjustment Disorder (Code – None)
- Culture Shock (Code – None)

Internet Resources
http://www.athealth.com/Consumer/disorders/Adjustment.html
http://www.psyweb.com/Mdisord/adjd.html
http://soe.drake.edu/nri/syllabi/reha222/psychmods/Adjustment/default.html
http://www.ahealthyme.com/article/gale/100084999

Movie Suggestions
- There are no specific movies offered for Adjustment Disorders.

Additional Disorders

Culture Shock
Disorientation often accompanied by feelings of isolation and rejection. This is due to radical change in culture, through migration to a different country or when a person's culture is confronted by an alien culture. In severe cases it may lead to Adjustment Disorder. See Culture Bound Disorders
Anxiety Disorders

Individuals with Anxiety Disorders experience abnormal or inappropriate levels of heightened anxiety. These individuals do not react to particular stimuli with the normal Fight or Flight response: that is, by either fighting or abandoning the environment or situation. Instead, these individuals become overly anxious as a result of the presence or anticipation of the presence of a particular stimulus; their reaction to the stimulus is unwarranted.

Disorders in this Category

- Acute Stress Disorder (Code – 308.3)
- Agoraphobia With History of Panic Disorder (Code – None)
- Agoraphobia Without History of Panic Disorder (Code – 300.22)
- Anaclitic Depression (Code – None)
- Anxiety Disorder Due to a General Medical Condition (Code – 293.84)
- Anxiety Disorder Not Otherwise Specified (Code – 300.00)
- Anxiety Hysteria (Code – None)
- Chandler Long-Term Syndrome (Code – None)
- Compulsive Hoarding (Code – None)
- Defense Hysteria (Code – None)
- Exaggerated Startle Reaction (Code – None)
- Familial Startle Disease (Code – None)
- Generalized Anxiety Disorder (Code – 300.02)
- Harming Disorder (Code – None)
- Hoarding Disorder (Code – None)
- Hospitalism (Code – None)
- Hyperekplexia (Code – None)
- Hyperexplexia (Code – None)
- Hyperstartle Disorder (Code – None)
- Hypnoid Hysteria (Code – None)
- Hysteria (Code – None)
- Kok Disease (Code – None)
- Marshall Long-Term Syndrome (Code – None)
- Maternal Deprivation (Code – None)
- Obsessional Neurosis (Code – None)
- Obsessive-Compulsive Disorder (Code – 300.3)
- Overanxious Disorder (Code – None)
- Panic Disorder With Agoraphobia (Code – 300.21)
- Panic Disorder Without Agoraphobia (Code – 300.01)
- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (Code – None)
- Posttraumatic Stress Disorder (Code – 309.81)
- Raggin’ Cajun (Code – None)
- Retention Hysteria (Code – None)
- Separation Anxiety (Code – None)
- Simple Phobia (Code – None)
• Social Phobia (Code – 300.23)
• Specific Phobia (Code – 300.29)
• Startle Disorder (Code – None)
• Substance-Induced Anxiety Disorder (Code – None)
• Survivor Syndrome (Code – None)
• Transference Neurosis (Code – None)
• Werther Syndrome (Code – None)

Internet Resources
http://www.nimh.nih.gov/healthinformation/anxietymenu.cfm
http://panicdisorder.about.com/
http://www.psych.org/public_info/anxiety.cfm
http://www.baltimorepsych.com/anxiety.htm
http://pacificcoast.net/~kstrong/

Movie Suggestions
• Alive
• All Quiet on the Western Front
• Analyze This
• Arachnophobia
• As Good as it Gets
• Aviator
• Best Years of Our Lives, The
• Big Parade, The
• Birds, The
• Birdy
• Black Rain
• Born on the Fourth of July
• Casualties of War
• Chattahoochee
• Coming Home
• Copy Cat
• Creepshow
• Deer Hunter, The
• End of Innocence, The
• Fear Inside, The
• Fearless
• Fisher King, The
• Forces of Nature
• Full Metal Jacket
• Hamburger Hill
• High Anxiety
• Home of the Brave
• House of Games
• I Never Sang for my Father
• I'll Be Seeing You
• In Country
• In Person
• Inside Out
• It's a Wonderful Life
• Jacknife
• Jacob’s Ladder
• Let There Be Light
• Lunatics: A Love Story
• Manchurian Candidate, The
• MASH
• Matchstick Man
• Now Voyager
• Obsession
• Odd Couple, The
• Ordinary People
• Panic
• Paths of Glory
• Patton
• Pawn Broker, The
• Raiders of the Lost Ark
• Regeneration
• San Francisco
• Shoah
• Slaughterhouse Five
• Spellbound
• Touching Tree, The
• Twelve O' Clock High
• Unmarried Woman, An
• Vertigo
• What About Bob?
• Who'll Stop the Rain
• Wrong Man, Th
Additional Disorders

Anaclitic Depression
A form of Depression manifested by infants, usually triggered by sudden separation from a parent after having had a normal relationship for at least six months; anaclitic depression is characterized by crying, apprehension, withdrawal, Anorexia, and Dyssomnias. The disorder was introduced and named in 1946 by the Austrian psychoanalyst René A. Spitz (1887–1974).

Anxiety Hysteria
In psychoanalysis, a neurosis with a phobia as its central symptom. The term was introduced in 1908 by the Austrian psychiatrist Wilhelm Stekel (1868–1940) in his book Nervöse Angstzustände und ihre Behandlung (Neurotic Anxiety States and Their Treatment) specifically to emphasize its structural resemblance to Conversion Hysteria, now called Dissociative Disorder.

Chandler Long-Term Syndrome
Similar to Posttraumatic Stress Disorder, Chandler Long-Term Syndrome is a low-grade trauma experienced by the victimizer rather than the victim. In this case, the victimizer commits an act of some kind, theft, aggression, sexual behavior, condemnation, back stabbing, rumor mongering, etc., where over time—short or long term—the victimizer comes to believe and realizes that what he or she has done was unconscionable, leading to guilt, remorse, and regret. While the victim may not know he or she was victimized, the victimizer carries the feelings related to the behavior, often unbeknownst to the victim. Over time, the feelings manifest and may take various forms such as Depression, anger, substance use, sleep disorders, etc. The victimizer often feels that there is no way to release the guilt relating to what they have done. Additionally, because he or she may suppress the feelings, the low-grade trauma may escalate in intensity over time. (Chandler Long-Term Syndrome was identified by Gary Solomon, MPH, M.S.W., Ph.D., and Professor of Psychology. See also Retention Hysteria (Pg. 317).

Compulsive Hoarding
Compulsive Hoarding is a complex psychological disorder that can significantly disrupt a person's life. Hoarding occurs when a person acquires and saves possessions that have either little or no value or have some perceived value; the person then has great difficulty in discarding the accumulated items. This usually results in clutter. Hoarding behavior can often lead to other problems. Often associated with Obsessive-Compulsive Disorder or Obsessive-Compulsive Personality Disorder and Depression, hoarding can affect people's lives across all levels of functioning. It is common for hoarders to have interpersonal difficulties, family tension, poor self-esteem, poor social skills, weak decision-making skills, occupational issues, and even legal issues. In addition, there are physical risks, such as falls and fires within the home environment.

Defense Hysteria
In psychoanalysis, one of three types of hysteria distinguished by Sigmund Freud (1856–1939) in 1894 in his article “The Neuro-Psychoses of Defense” and by the Austrian
physician Josef Breuer (1842–1925) and Freud in 1895 in their book *Studies on Hysteria*. Defense Hysteria is characterized by prolific use of defense mechanisms. After 1895 Freud came to believe that defense plays a part in all hysteria, and he abandoned the tripartite distinction, but others continued to use it.

Exaggerated Startle Reaction  
See Hyperekplexia (Pg. 315).

Familial Startle Disease  
See Hyperekplexia (Pg. 315).

Harming Disorder  
A form of Obsessive-Compulsive Disorder in which people experience repetitive and upsetting thoughts and/or behaviors involving thinking and fantasizing about harming others: parents, children, spouse, co-workers, etc. Additionally, these individuals may believe that they are running people down, or hurting or killing someone while driving.

Hoarding Disorder  
See Compulsive Hoarding

Hospitalism  
A term introduced in 1945 by the Austrian psychoanalyst René A. Spitz (1887–1974) to denote the physical and psychological effects on an infant (up to 18 months old) of prolonged and total separation from its mother, due to hospitalization or some other similar cause. According to Spitz, the characteristics include retarded physical development and disruption of perceptual-motor skills and language.

Hyperekplexia  
A genetic disorder also known as Hyperexplexia in which babies have an exaggerated startle reflex (reaction). This disorder was not recognized until 1962 when it was described by Drs. Kok and Bruyn as a disease with the onset at birth of hypertonia (stiffness), exaggerated startle response, strong brain-stem reflexes (especially head-retraction reflex) and, in some cases, epilepsy. The hypertonia (stiffness) was evident with flexion of limbs, disappeared during sleep, and diminished over the first year of life. The startle reflex was sometimes accompanied by acute generalized hypertonia (sudden stiffness) causing the person to fall like a log to the ground. There were 29 affected males and females in 6 generations, indicating that the disorder is an autosomal (non-sexlinked) dominant trait. Also known as Hyperexplexia, Exaggerated Startle Reaction, Familial Startle Disease, Kok Disease, and Raggin’ Cajun.

Hyperekplexia  
See Hyperekplexia (Pg. 315).

Hyperstartle Disorder  
See Hyperekplexia (Pg. 315).
Hypnoid Hysteria
In psychoanalysis, one of three types of hysteria that were distinguished in 1895 by the Austrian physician Josef Breuer (1842–1925) and Sigmund Freud (1856–1939) in *Studies on Hysteria*, supposedly originating in a state similar to a hypnotic state. However, Freud wrote, “Strangely enough, I have never in my own experience met with a genuine hypnoid hysteria. Any that I took in hand has turned into defense hysteria.” After 1895, Freud came to believe that all hysteria is defense hysteria, and he abandoned the tripartite distinction.

Hysteria
Formerly, a neurosis whose principal features consists of emotional instability, repression, dissociation, physical symptoms, and vulnerability to suggestion.

Kok Disease
See Hyperekplexia (Pg. 315).

Marshall Long-Term Syndrome
Similar to Posttraumatic Stress Disorder, Marshall Long-Term Syndrome is a low grade trauma experienced by an individual who may not acknowledge or know that he or she was traumatized or victimized. For example, the individual may have entered into an agreement that, in hindsight, he or she comes to believe was a bad deal. The other individual(s) involved in the transaction may have no idea about the first individual’s traumatic experience. The individual may carry the guilt, anger, regret, frustration, etc., of their experience often unbeknownst to anyone, but themselves. In fact, he or she may not have a conscious sense of the traumatic event. Over time, the feelings may manifest and translate into various forms such as Depression, anger, substance use, avoidance, isolation, fear, an inability to commit, etc. The individual often feels that there is no way to release or resolve these feelings. Additionally, because he or she may suppress the feelings, the low-grade trauma may escalate in its intensity over time. (Marshall Long-Term Syndrome was identified by Gary Solomon, MPH, M.S.W., Ph.D., and Professor of Psychology.) See also, Retention Hysteria (Pg. 317).

Maternal Deprivation
Inadequate mothering, whether delivered by the mother or another primary care person, during the first six months of life, leading to a failure of attachment, or more generally, inadequate mothering during the first five years of life. The concept was introduced by the English psychiatrist (Edward) John (Mostyn) Bowlby (1907–90), who argued in his book *Child Care and the Growth of Love* (1953) that maternal deprivation could seriously affect a child's development and lead to psychological problems and juvenile delinquency. Early research tended to support the theory, but subsequent research suggested that the adverse effects were often caused by other factors that tend to accompany Maternal Deprivation, such as physical neglect.

Obsessional Neurosis
Another name for an Obsessive-Compulsive Disorder. The term was introduced in
German (Zwangsneurose) by Sigmund Freud (1856–1939) in an article entitled “Heredity and the Aetiology of the Neuroses” (1896): “I was obliged to begin my work with a nosological innovation. I found reason to set alongside of hysteria the Obsessional Neurosis as a self-sufficient and independent disorder.”

**Overanxious Disorder**

A childhood anxiety disorder, not included in the DSM-IV classification, corresponding to Generalized Anxiety Disorder in adults, in which anxiety is focused on such matters as personal appearance, health, and academic or sporting achievement at school.

**Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections**

Over the last ten years, there has appeared a mounting body of evidence that suggests there is a small subgroup of individuals whose childhood onset Obsessive-Compulsive Disorder may have been triggered by streptococcal throat infections. This association of an infectious cause with a neurobiological disorder may also be true for Tic Disorders, Trichotillomania, and possibly Attention-Deficit/Hyperactivity Disorder. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections is referred to as PANDAS.

**Raggin’ Cajun**

See Hyperekplexia (Pg. 315).

**Retention Hysteria**

In psychoanalysis, one of three types of hysteria distinguished in 1895 by the Austrian physician Josef Breuer (1842–1925) and Sigmund Freud (1856–1939) in *Studies on Hysteria* (Standard Edition, II, at pp. 169–73), supposedly characterized by emotions that have not undergone abreaction and are therefore retained. After 1895, Freud came to believe that all hysteria is defense hysteria, and he abandoned the tripartite distinction.

**Separation Anxiety Disorder**

A mental disorder with onset before age 18 years, characterized by developmentally inappropriate and excessive separation anxiety relating to separation from home or from major attachment figures. Symptoms, which to satisfy the diagnostic criteria must persist for at least 4 weeks and must cause clinically significant distress or social, academic, or occupational problems, may include unrealistic fear of losing major attachment figures or of harm befalling them, refusal to attend school, refusal to sleep alone, repeated nightmares about separation, and complaints of somatic symptoms such as headaches, nausea, or vomiting when separation is threatened.

**Simple Phobia**

See Specific Phobia (Pg. 291).

**Startle Disorder**

See Hyperekplexia (Pg. 315).

**Survivor Syndrome**
A term introduced by the US psychiatrist Robert Jay Lifton (b. 1926) for a pattern of responses often seen in survivors of terrible ordeals, the most important symptoms being Anhedonia, Chronic Anxiety, Depression, Dyssomnias, and Nightmares.

Transference Neurosis
See Obsessional Neurosis (Pg. 316).

Werther Syndrome
A pattern of imitative cluster suicides following the well-publicized suicide of a famous person.
Culture-Bound (Disorders) Syndromes

Patterns of aberrant behavior that do not fit easily into standard classifications of mental disorders and are entirely or mainly restricted to particular cultural groups, usually and ethnocentrically excluding disorders such as Anorexia Nervosa that are restricted to Western industrial cultures. Social class and gender may further impact patterns of behavior both within and outside a given culture.

Disorders in this Category

- Amok (Code – None)
- Ataque De Nervios (Code – None)
- Bilis (Code – None)
- Bouffée Déliante (Code – None)
- Brain (Code – None)
- Cafard (Code – None)
- Colera (Code – None)
- Dhat (Code – None)
- Espanto (Code – None)
- Fag Brujeria (Code – None)
- Falling Out (Code – None)
- Ghost Sickness (Code – None)
- Grisi Siknis (Code – None)
- Hi-Waitck (Code – None)
- Hsieh-Ping (Code – None)
- Hwa-Byung (Code – None)
- Iich'aa (Code – None)
- Koro (Code – None)
- Latah (Code – None)
- Locura (Code – None)
- Mal De Ojo (Code – None)
- Mal De Pelea (Code – None)
- Mal Puesto (Code – None)
- Nervios (Code – None)
- Pa-Leng (Code – None)
- Perdida Del Alma (Code – None)
- Pibloktoq (Code – None)
- Qi-Gong Psychotic Reaction (Code – None)
- Rootwork (Code – None)
- Saka (Code – None)
- Sangue Dormido (Code – None)
- Shenjing Shuairuo (Code – None)
- Shen-K'uei (Code – None)
- Shin-Byung (Code – None)
- Shinkei-Shitsu (Code – None)
• Spell (Code – None)
• Susto (Code – None)
• Tabanka (Code – None)
• Taijin Kyofusho (Code – None)
• Tripa Ida (Code – None)
• Ufufunyane (Code – None)
• Uqamairineq (Code – None)
• Windigo (Code – None)
• Zar (Code – None)

Internet Resources
http://www.nursingworld.org/tan/98janfeb/mental.htm
http://www.psychiatrictimes.com/p011163.html

Movie Suggestions
• There are no specific movies offered for Culture-Bound (Disorders) Syndromes.

Additional Disorders

Amok
A culture-bound syndrome originally reported in Malaysia, but later also in Indonesia, Laos, the Philippines, Papua New Guinea, Polynesia, Puerto Rico, and among the Navajo in North America, characterized by a period of hostile brooding, often precipitated by a perceived insult or affront, followed by an outburst of uncontrolled aggression directed at people and objects in the vicinity (running amok) with paranoid ideation and automatism, followed by exhaustion and amnesia regarding the violent behavior. It is often interpreted in Western cultures as a Dissociative Disorder.

■ From Malay – amoq, a furious assault.

Ataque De Nervios
A culture-bound syndrome found mainly among Latino communities in the Caribbean, but also in many Latin American and Mediterranean cultures, characterized by outbursts of uncontrollable shouting, crying, trembling, a sensation of heat in the chest rising to the head, and aggression, both verbal and physical, accompanied by a sense of loss of control, generally precipitated by a psychosocial stressor such as Bereavement, divorce, or a family conflict. It is sometimes interpreted as a form of panic attack.

■ From Spanish – ataque, attack + de, of + nervios, nerves, hence literally an attack of nerves.

Bilis
A culture-bound syndrome found in many Latin American communities, characterized by intense anger or rage, accompanied by acute nervous tension, headache, trembling,
screaming, stomach upset, and even loss of consciousness, often followed by chronic fatigue or asthenia, interpreted locally as a result of a disturbance in the balance of humors in the body. Also called Colera or Muina.

- From Spanish – *bilis*, bile; from Latin – *bilis*, bile.

**Bouffée Déliante**

A culture-bound syndrome of Francophone West Africa and Haiti, characterized by sudden outbursts of violent behavior, accompanied by confusion, psychomotor agitation, and sometimes also paranoid ideation and hallucinations. It is sometimes interpreted as a Brief Psychotic Disorder.

- From French – *bouffée explosion + délirante*, raving.

**Brain Fag**

A culture-bound syndrome originally reported among English-speaking school and university students in West Africa, who attributed it to overwork, characterized by loss of ability to concentrate, learn, remember, or think, usually accompanied by sensations of pain, pressure, or tightness around the head or neck and blurred vision.

- From – *fag*, in the sense of being fagged out or exhausted, perhaps from flag to droop.

**Brujeria**

A name for Rootwork in Spanish-speaking communities of the Caribbean and the southern United States, where it is also called “mal puesto.”

- From Spanish – *brujeria*, witchcraft; from *bruja*, a witch.

**Cafard**

A variant name for Amok in Polynesia. Also called Cathard.

- From French – *cafard*, a cockroach or hypocrite.

**Colera**

Another name for Bilis.

- From Spanish – *colera*, bile.

**Dhat**

A culture-bound syndrome found in India, where there is another similar syndrome called Jiryan, and in Sri Lanka, where a syndrome resembling Dhat is called Sukra Prameha, characterized by severe anxiety, together with hypochondria focused on concerns about weakness and exhaustion, attributed to excessive discharge of semen by both men and women (also believed to secrete semen), and whitish discoloration of urine interpreted as semen loss. Also written Dhatu. Compare Shen-k'uei.

- From Hindi – *dhatura*, a plant with strongly narcotic properties.

**Espanto**

Another name for Susto.

- From Spanish – *espanto*, fright or terror; from espantar, to scare or frighten.
Falling Out
A culture-bound syndrome found among communities in the southern United States and the Caribbean, characterized by a sudden collapse, occurring either without warning or after a brief spell of dizziness, followed by a sensation of blindness, although the eyes are open, and an inability to speak or move although the person is aware of what is happening in the immediate vicinity. It is sometimes interpreted as a Conversion Disorder or a Dissociative Disorder.

Ghost Sickness
A culture-bound syndrome found in many American Indian tribes, characterized by thanatophobia, necromania, nightmares, asthenia, feelings of danger, anorexia, fainting, dizziness, anxiety, and hallucinations, the symptoms often being attributed by the afflicted person to witchcraft.

Grisi Siknis
A culture-bound syndrome found among Miskito Indians of Nicaragua. Symptoms include headache, anxiety, anger, aimless running. Some similarities to Pibloktoq.

Hi-Wa itck
A culture-bound syndrome found among Mohave American Indians. Symptoms include insomnia, Depression, loss of appetite, and sometimes suicide associated with unwanted separation from a loved one.

Hsieh-Ping
A culture-bound syndrome found among Taiwanese. Symptoms include a brief trance state during which one is possessed by an ancestral ghost, who often attempts to communicate to other family members. Symptoms include tremor, disorientation and Delirium, and visual or auditory hallucinations.

Hwa-Byung
A culture-bound syndrome of Korea and emigrant Korean communities in other countries, attributed locally to suppression of anger, characterized by panic attacks, dyspnoea, thanatophobia, insomnia, anorexia, palpitation, fatigue, joint or muscle pains, indigestion, and a sense of fullness in the pit of the stomach.

From Korean – hwa-byung, anger syndrome.

Iich'aa
A variant name for Amok among the Navajo Indians of North America.

Koro
A culture-bound syndrome restricted mainly to male members of ethnic Chinese communities in southern and eastern Asia and elsewhere, sometimes occurring in localized epidemics, characterized by sudden and intense anxiety that the penis is shrinking and is liable to retract into the abdomen, resulting in death. In an effort to prevent this from happening, afflicted men often hold on to their penises during the day and wear commercially available bamboo clamps while sleeping. A less common female
variant of the syndrome, focused on fear of the nipples or vulva retracting, is also recognized. Also called Shook Yong, Shuk Yang, Suk Yeong, or Suo Yang in Chinese-speaking areas, Rok-joo in Thailand, and Jinjinia Bemar or Jinjin in northeastern India.

- From Malay – *koro*, to shrink.

**Latah**

A culture-bound syndrome found mainly in Malaysian and Indonesian cultures, most often among middle-aged women, but reported occasionally in Thailand (where it is called Bah Tschi or Baah-ji), the Philippines (Malimali or Silok), among the native Ainu people of Japan (Imu), in Siberia (Amurakh, Irkunii, Ikota, Olan, Myriachit, or Menkeiti), and in southern Africa (Latah), in which a person after experiencing a sudden fright or shock displays abnormal suggestibility, accompanied by Echolalia, Echopraxia, and a state resembling a trance. Also spelled “Lattah.”

- From Malay.

**Locura**

A culture-bound syndrome resembling a chronic psychosis found in several parts of Latin America and among Latino communities in the United States and elsewhere, with signs and symptoms such as incoherence, psychomotor agitation, auditory and visual hallucinations, and sometimes outbursts of violent or aggressive behavior. It is often interpreted as a form of Schizophrenia.

- From Spanish – *locura*, madness.

**Mal De Ojo**

A culture-bound syndrome, sometimes referred to in English as the evil eye, widespread throughout Mediterranean cultures and Latino communities in other parts of the world, to which children are supposed to be especially vulnerable, believed to be caused by a malignant look or glance from a malevolent person, leading to insomnia, crying without provocation, diarrhea, vomiting, and fever.

- From Spanish – *mal*, illness + *de*, of + *oj*o, an eye.

**Mal De Pelea**

A variant name for Amok in Puerto Rico.

- From Spanish – *mal*, illness + *de* of + *peleo*, tussle or quarrel.

**Mal Puesto**

A name for Rootwork in Spanish-speaking communities of the Caribbean and the southern United States, where it is also called Brujeria.

- From Spanish – *mal puesto*, badly placed; from *mal*, badly + *poner*, to place.

**Nervios**

A culture-bound syndrome widespread throughout Latin America and among Latino communities in the United States and elsewhere, also found in Egypt (where it is called Nerfiza) and Greece (Nevra), characterized by chronic anxiety and sorrowfulness, interpreted as a general state of vulnerability to psychosocial stressors brought about by personal or family difficulties, with a broad range of signs and symptoms, commonly...
including anorexia, dyssomnias, headaches, irritability, stomach upsets, tearfulness, loss of concentration, tremor, paraesthesia, and dizziness or vertigo.

- From Spanish – *nervios*, nerves; from Latin – *nervus*, a nerve.

**Pa-Leng**

A culture-bound syndrome found in China and southeast Asia, characterized by pathological fear of cold (frigophobia) and of wind (anemophobia), believed to produce fatigue, impotence, and death. Also called Frigophobia.

- From Chinese – *pa*, fear + *leng*, cold or the cold season.

**Perdida Del Alma**

Another name for *Susto*.

- From Spanish – *perdida* loss + *del*, of + *alma*, soul.

**Pibloktoq**

A culture-bound syndrome, sometimes called Arctic Hysteria in English, restricted mainly to Inuit communities of North America and Greenland, characterized by a period of fatigue, social withdrawal, confusion, and irritability lasting for a few hours or days, leading up to an abrupt episode of dissociation that usually lasts only minutes, during which the afflicted person may strip or tear off clothes, roll in the snow, run about in a frenzied state, shout obscenities, destroy property, engage in other violent, dangerous, or antisocial forms of behavior, and manifest Pseudolalia, Echolalia, and Echopraxia, before lapsing into convulsions and losing consciousness, followed typically by complete amnesia regarding the dissociative episode.

- From Inuit – *piblokto*, frenzy.

**Qi-Gong Psychotic Reaction**

A culture-bound syndrome included in CCMD-2 (the Chinese Classification of Mental Disorders, 2nd ed.), restricted mainly to Chinese communities in southern and eastern Asia and elsewhere, the onset invariably following participation in qi-gong, a system of meditational exercises involving deep breathing believed to promote physical and spiritual well-being, characterized by a time-limited period of paranoid ideation, dissociation, and psychotic signs and symptoms.

- From Chinese – *qi-gong*, exercise of vital energy; from *qi*, energy + *gong*, skill or exercise.

**Rootwork**

A culture-bound syndrome found in the Caribbean and among African-American and Latino communities in the southern United States, where it is generally attributed to witchcraft, sorcery, or hexing; characterized by anxiety, gastrointestinal complaints such as nausea, vomiting, and diarrhea, weakness, dizziness, and fear of being poisoned or killed, the symptoms generally persisting unless the spell is removed by a healer called a root doctor. Also called Mal Puesto or Brujeria in Spanish-speaking communities.

- From Old English – *rot*, a root; from Old Norse – *rot*, a root.

**Saka**

See Ufufunyane.
Sangue Dormido
A culture-bound syndrome largely confined to Portuguese-speaking Cape Verde Islanders and emigrant Cape Verde communities in other parts of the world, the symptoms of which may include muscle and joint pain, numbness, trembling, paralysis, convulsions, stroke, blindness, heart attack, and (among pregnant women) miscarriage.
- From Spanish – sangue, blood; from Latin – sanguis, blood + Spanish – dormido, sleeping; from Latin – dormire, to sleep.

Shenjing Shuairuo
A culture-bound syndrome included in CCMD-2 (the Chinese Classification of Mental Disorders, 2nd ed.), found mainly among Chinese communities in southern and eastern Asia, characterized by fatigue, dizziness, headaches, joint and muscle pain, loss of concentration, gastrointestinal complaints, sexual dysfunctions, assorted dyssomnias, and amnesia. It is sometimes interpreted in Western cultures as an Anxiety Disorder or a Mood Disorder.
- Chinese term for neurasthenia; from – shenjing, a nerve + shuairuo, weak.

Shen-K'uei
A culture-bound syndrome found mainly among men in Thailand and in ethnic Chinese communities in southern and eastern Asia, characterized by anxiety and panic attacks accompanied by somatic symptoms such as insomnia, sexual dysfunctions, dizziness, backache, and fatigue, the symptoms often being attributed to loss of semen brought about by excessive sexual intercourse, masturbation, nocturnal emissions (wet dreams), and the passing of whitish urine believed to contain semen. Spelled “Shenkui” in Chinese-speaking communities.
- From Thai or Chinese – shen, spirit + k'uei or kui, deficit or wastage.

Shin-Byung
A culture-bound syndrome restricted mainly to Korea and Korean communities living elsewhere, characterized by anxiety, dissociation, insomnia, anorexia, dizziness, and fatigue, together with somatic symptoms such as gastrointestinal complaints and general asthenia, the symptoms generally being attributed to possession by the spirits of dead ancestors.
- From Korean – shin, spirit + byung, possession.

Shinkei-Shitsu
Another name for Taijin Kyofusho.
- From Japanese – shinkei-shitsu, nervous temperament; from shinkei, a nerve + shitsu, constitution or nature.

Spell
A culture-bound syndrome widespread in sub-Saharan Africa and among African-American and Latino communities in the southern United States and elsewhere, characterized by brief episodes of personality change during which the person experiencing the spell believes that some form of communication is taking place with
dead relatives or their spirits. A person with this pattern of experiences is endowed locally with dignity and respect and usually considers it a privilege resulting from being appointed by dead ancestors as a diviner; hence this disorder is distinguished sharply from Ufufunyane, which is feared and despised and is associated with evil spirits.

- From Old English – *spell*, speech, from *spellian*, to speak or announce

**Susto**

A culture-bound syndrome found in Peru and other parts of Latin America and among Spanish-speaking communities in the United States and elsewhere, in which, following a frightening experience (sometimes weeks, months, or even years later), the soul is believed to have departed the body, resulting in symptoms such as psychomotor agitation, anorexia, insomnia or hypersomnia, nightmares, and depressed mood, together with somatic complaints such as muscle and joint pain, headaches, and diarrhea.

- From Spanish – *susto*, fright or scare.

**Tabanka**

A culture-bound syndrome found in Trinidad. Symptoms include Depression associated with a high rate of suicide; seen in men abandoned by their wives.

**Taijin Kyofusho**

Found in Japan and included in the official Japanese classification of mental disorders; characterized by an intense and debilitating anxiety that one's body or its parts or functions are embarrassing, displeasing, repugnant, or offensive to others. Also called Shinkei-shitsu. It is sometimes interpreted in Western cultures as a Body Dysmorphic Disorder.

- From Japanese – *taijin*, confrontation + *kyofu-sho*, phobia; from *kyofu*, fear + *sho*, nature or kind.

**Tripa Ida**

Another name for Susto.

- From Spanish – *tripa*, intestine (believed in the past to be the seat of the soul) + *ida*, departure.

**Ufufunyane**

A culture-bound syndrome found mainly among young women in Zulu-speaking and Xhosa-speaking communities of southern Africa, and in Kenya where it is called aka, attributed locally to spirit possession, witchcraft, or magical potions administered by rejected lovers or enemies, characterized by shouting, sobbing, pseudolalia, paralysis, convulsions, nightmares with sexual themes, and trance or loss of consciousness. It is feared and despised among local communities and is sharply distinguished from Thwasa (see Spell). Among Xhosa-speaking people the plural form Amafufunyane is used to denote the syndrome.

- From Zulu – *ufufunyane*, a character or voice that has entered and taken control of a person; from *ukufuya*, to possess (such things as herds of cattle) or to treat a person as a possession.
Uqamairineq
A culture-bound syndrome restricted mainly to Inuit communities of North America and Greenland, characterized by a sensation of a peculiar sound or smell, followed by sudden paralysis accompanied by anxiety, psychomotor agitation, or hallucinations, usually lasting only minutes and attributed to soul loss or spirit possession. It is sometimes interpreted as a type of Dissociative Disorder.

Windigo
A rare culture-bound syndrome found among North American Indian tribes in the subarctic cultural area, characterized by symptoms such as Depression, homicidal or suicidal thoughts, and a compulsive desire to eat human flesh, often prompting warnings to family and friends to get as far away as possible, followed by the afflicted person turning into a cannibal, being regarded locally as a monster and generally ostracized or put to death. The reality of this syndrome, as opposed to its status as a localized folk myth, is controversial. Also spelled “Wendigo” or “Whitigo.”
- From Ojibwa – wintiko, a flesh-eating monster.

Zar
A culture-bound syndrome found in Ethiopia and other areas of North Africa, and among Arab communities in various parts of the Middle East, characterized by episodes of dissociation that are locally attributed to spirit possession and are associated with signs and symptoms such as shouting, laughing, self-injury or self-mutilation, singing and weeping, often followed by apathy and withdrawal. The condition is traditionally dealt with through elaborate ceremonies of exorcism involving singing, dancing, and drinking the blood of a sacrificed ram.
- From Amharic – zar, an evil spirit.
Delirium, Dementia, Amnestic and Other Cognitive Disorders

Individuals with Delirium, Dementia, Amnestic and Other Cognitive Disorders have problems with cognition; processing information. This chronic or persistent disorder is due to disease or injury. Memory problems, thinking problems, personality changes, and impaired reasoning characterize this problem. The memory and thinking problems relate to storage, retrieval, and manipulation of information.

Disorders in this Category

**Delirium**
- Delirium Due to a General Medical Condition (Code – 293.0)
- Delirium Due to Multiple Etiologies (Code – None)
- Delirium Not Otherwise Specified (Code – 780.09)
- Substance-Induced Delirium (Code – None)

**Dementia**
- Dementia Due to a General Medical Condition (Code – None)
- Dementia Due to Creutzfeldt-Jakob Disease (Code – 2941x)
- Dementia Due to Head Trauma (Code – 2941x)
- Dementia Due to HIV Disease (Code – 2941x)
- Dementia Due to Huntington’s Disease (Code – 2941x)
- Dementia Due to Multiple Etiologies (Code – None)
- Dementia Due to Parkinson’s Disease (Code – 2941x)
- Dementia Due to Pick’s Disease (Code – 2941x)
- Dementia Not Otherwise Specified (Code – 294.8)
- Dementia of the Alzheimer’s Type (Code – 294.1x)
- Dementia Praecox (Code – None)
- Lewy Body Dementia (Code – None)
- Multi-Infarct Dementia (Code – None)
- Pick's Disease (Code – None)
- Substance-Induced Persisting Dementia (Code – None)
- Vascular Dementia (Code – 290.4x)

**Amnestic**
- Alcohol Amnestic Disorder (Code – None)
- Alcohol Amnestic Syndrome (Code – None)
- Amnestic Disorder Not Otherwise Specified (Code – 294.4)
- Amnestic Due to a General Medical Condition (Code – 294.0)
- Childhood Amnesia (Code – None)
- Confabulation (Code – None)
- Diencephalic Amnesia (Code – None)
- Doppelgänger (Code – None)
- Global Amnesia (Code – None)
• Infantile Amnesia (Code – None)
• Korsakoff's Psychosis (Code – None)
• Korsakoff's Syndrome (Code – None)
• Organophosphate Poisoning (Code – None)
• Psychogenic Amnesia (Code – None)
• Psychogenic Fugue (Code – None)
• Reduplicative Paramnesia (Code – None)
• Source Amnesia (Code – None)
• Substance-Induced Persisting Amnestic Disorder (Code – None)
• Transient Global Amnesia (Code – None)

Other Cognitive Disorders
• Cognitive Disorder Not Otherwise Specified (Code – 294.9)
• Cruise Effect (Code – None)
• Déjà vu (Code – None)
• Eyewitness Misinformation Effect (Code – None)
• False Memory (Code – None)
• False Memory Syndrome (Code – None)
• Misinformation Effect (Code – None)
• Paramnesia (Code – None)
• Piaget Kidnaping Memory (Code – None)
• Recovered Memory (Code – None)
• Stockholm Syndrome (Code – None)

Internet Resources
http://www.nurses.info/mental_health_dementia.htm/
http://www.hon.ch/HONselect/Selection/F03.087.html
http://www.planetpsych.com/zPsychology_101/Disorders/cognitive_disorders.htm
http://omni.ac.uk/browse/mesh/D019965.html
http://www.use.hcn.com.au/subject.%60Delirium,%20Dementia,%20Amnestic,%20Cognitive%20Disorders%60/home.html

Movie Suggestions
• Alive
• All Quiet on the Western Front
• Analyze This
• Arachnophobia
• As Good as it Gets
• Aviator
• Best Years of Our Lives, The
• Big Parade, The
• Birds, The
• Birdy
• Black Rain
• Born on the Fourth of July
• Casualties of War
• Chattahoochee
• Coming Home
• Copy Cat
• Creepshow
• Deer Hunter, The
• End of Innocence, The
• Fear Inside, The
• Fearless
• Fisher King, The
• Forces of Nature
• Full Metal Jacket
• Hamburger Hill
• High Anxiety
• Home of the Brave
• House of Games
• I Never Sang for My Father
• I'll Be Seeing You
• In Country
• In Person
• Inside Out
• It's a Wonderful Life
• Jacknife
• Jacob’s Ladder
• Let There Be Light
• Lunatics: A Love Story
• Manchurian Candidate, The
• MASH
• Matchstick Man
• Now Voyager

• Obsession
• Odd Couple, The
• Ordinary People
• Panic
• Paths of Glory
• Patton
• Pawn Broker, The
• Raiders of the Lost Ark
• Regeneration
• San Francisco
• Shoah

• Slaughterhouse Five
• Spellbound
• Touching Tree, The
• Twelve O' Clock High
• Unmarried Woman, An
• Vertigo,
• What About Bob?
• Who'll Stop the Rain
• Wrong Man, The

Additional Disorders

Alcohol Amnestic Syndrome – *Amnestic*
  See Korsakoff’s Psychosis

Alcohol Amnestic Disorder – *Amnestic*
  See Korsakoff's Psychosis.

Childhood Amnesia
  See Infantile Amnesia – *Amnestic*

Confabulation – *Amnesia*
  A memory disorder related to amnesia, but involving the generation of fabricated accounts of events, experiences, or facts, either deliberately or without conscious intent, to compensate for memory loss. Some authorities think of it as “honest lying.” It is a common sign of Korsakoff's Psychosis.

- From Latin – *con-*, with + *fabula*, a story + *(a)tion*, indicating a process or condition.

Cruise Effect
  As a result of misinformation offered or suggested by someone who maintains an iconic post, individuals who react, respond and comply to this misinformation may unwittingly be harmed or harm others. The Cruise Effect emanates from statements made in 2005 by Tom Cruise, actor, who publically suggested that medications such as antidepressants serve no positive function. Adolph Hitler had a similar impact when he misused and conveyed misinformation on Darwinian Theory. The was identified by Gary Solomon, MPH, M.S.W., Ph.D., Professor of Psychology.

Déjà vu – *Other Cognitive Disorders*
  A form of Paramnesia distinguished by a Delusion of having already seen or experienced before something that is in reality being encountered for the first time. Less common variants include déjà entendu (already heard), déjà éprouvé (already experienced or tested), déjà fait (already done), déjà pensé (already thought), déjà raconté (already told or recounted), déjà voulu (already desired).
From French – *déjà*, already + *vu*, seen.

**Diencephalic Amnesia** – *Amnesia*
A form of Amnesia resulting from loss of neurons in the diencephalon, especially the midline thalamus and the mammillary bodies of the hypothalamus. This pattern of pathology is often associated with Korsakoff's Psychosis or Syndrome as a consequence of alcohol abuse and thiamine deficiency.

**Doppelgänger** – *Amnesia*
A Deduplicative Paramnesia in which a person believes that he or she has a double or replica.

**Eyewitness Misinformation** – *Cognitive Disorder Not Otherwise Specified*
A phenomenon whereby misleading post-event information distorts an eyewitness's recall of an event, as when a victim of a sexual assault who is subsequently told that an arrested suspect has a tattoo on his left arm comes to believe that she or he can recall seeing a tattoo on the perpetrator's arm. The effect may be caused by the post-event information overwriting the original memory or by the eyewitness becoming confused about the sources of different items of information, without the original memory necessarily being impaired. These processes were first studied systematically by the U.S. psychologists Elizabeth F. Loftus (b. 1944) and John Palmer (b. 1954), who reported their findings in the Journal of Verbal Learning and Verbal Behavior in 1974, and the effect was discussed at length by Loftus in her book Eyewitness Testimony (1979). In the original experiment, participants viewed a video recording of two cars colliding, and they were then asked how fast the cars were going when they hit or when they smashed into each other; when the word “smashed” was used in the question, the participants estimated the speed as 7 miles per hour faster, on average, than when the word “hit” was used, and a week later, 32 per cent of those exposed to the word “smashed” falsely recalled broken glass in the video, compared to only 14 per cent of those exposed to the word “hit.” Also called the Misinformation Effect.

**False Memory** – *Cognitive Disorder Not Otherwise Specified*
An apparent recollection of something that one did not actually experience, especially sexual abuse during infancy or childhood, often arising from suggestion implanted during counseling or psychotherapy. A classic example, though one unrelated to counseling and psychotherapy. See also, Piaget Kidnaping Memory.

**False Memory Syndrome** – *Cognitive Disorder Not Otherwise Specified*
A condition in which a person's identity and personal relationships are strongly influenced by an objectively false, but strongly believed memory of a traumatic experience, such as an objectively false recollection of sexual abuse by a parent or other relative or abduction by alien beings.
Global Amnesia – *Amnestic*
Severe or total anterograde amnesia resulting from damage to the diencephalon or medial temporal lobe, often accompanied by partial retrograde amnesia, with short-term memory and perceptual-motor skills generally remaining unimpaired. Compare transient global amnesia.

Infantile Amnesia – *Amnestic*
The inability of human adults to retrieve genuine memories for events that occurred before about three years of age. Faced with overwhelming evidence for this phenomenon, even the Austrian neurologist Sigmund Freud (1856–1939) was forced to accept it in his book Three Essays on the Theory of Sexuality (1905). See also, Childhood Amnesia.

Korsakoff's Psychosis – *Amnestic*
A mental disorder characterized by amnesia, especially an impairment in ability to retain newly acquired information, typically accompanied by confabulation—a tendency to invent explanations to cover areas of memory loss—but with other cognitive functions usually well-preserved, in contrast to Dementia. It is caused by a deficiency of thiamine (vitamin B1) usually resulting from Alcohol Dependence. Also called Alcohol Amnestic Disorder or Korsakoff's Syndrome. Named after the Russian neuropsychiatrist Sergei Sergeievich Korsakoff (1854–1900) who first described it in 1887.

Korsakoff's Syndrome – *Amnestic*
See Korsakoff's Psychosis

Lewy Body Dementia – *Dementia*
A form of Dementia, distinct from Alzheimer's Disease, associated with Lewy bodies in cortical neurons, especially in the frontal lobes, characterized by rapid and unpredictable fluctuations in levels of cognitive functioning and extremely poor reactions to neuroleptic drugs.

Misinformation Effect – *Cognitive Disorder Not Otherwise Specified*
See Eyewitness Misinformation (Pg. 330).

Multi-Infarct Dementia – *Dementia*
Another name for Vascular Dementia (Pg. 333)

Organophosphate Poisoning – *Amnestic*
A condition resulting from exposure to organophosphates, with signs and symptoms such as Amnesia, Generalized Anxiety, Depression, Aphasia, and Asthenia.

Paramnesia – *Other Cognitive Disorders*
A condition involving distorted memory or confusions of fact and fantasy.
Piaget Kidnaping Memory – *Cognitive Disorder Not Otherwise Specified*
A classic example of a false memory from the second year of life described by the Swiss psychologist Jean Piaget (1896–1980) and reproduced in English translation by the U.S. psychologist Elizabeth F. Loftus in her book *Eyewitness Testimony* (1979): “I was sitting in my pram, which my nurse was pushing in the Champs Élysées, when a man tried to kidnap me. I was held in by the strap fastened round me while my nurse bravely tried to stand between me and the thief. She received various scratches, and I can still see vaguely those on her face. Then a crowd gathered, a policeman with a short cloak and a white baton came up and the man took to his heels. I can still see the whole scene, and can even place it near the tube station. When I was about fifteen my parents received a letter from my former nurse saying that she had been converted to the Salvation Army. She wanted to confess past faults, and in particular to return the watch she had been given on this occasion. She had made up the whole story, faking the scratches. I, therefore, must have heard, as a child, the account of the story, which my parents believed, and projected it into the past in the form of a visual memory” (pp. 62–3).

Pick's Disease – *Dementia*
A progressive disorder commencing in middle age, caused by predominantly frontal lobe or temporal lobe impairment, characterized by Dementia with gradual personality change and deterioration of intelligence, memory, and language. Named after the Czech neurologist Arnold Pick (1851–1924) who first described it in 1892.

Praecox – *Dementia*
A continuously deteriorating psychosis whose symptoms begin early in life, a term coined by Emil Kraepelin.

Paramnesia – *Cognitive Disorder Not Otherwise Specified*
The sensation of remembering something that is being experienced for the first time: the sense of Déjà Vu.
- From Greek – *pro*, before + *mneme*, memory + *-ia*, indicating a condition or quality.

Psychogenic Amnesia – *Amnestic*
Any form of Amnesia arising by psychogenesis rather than as part of an organic disorder; similarly Psychogenic Fugue and Psychogenic Pain Disorder.

Psychogenic Fugue – *Amnestic*
A person forgets who they are and leaves home and create a new life; during the fugue there is no memory of the former life; after recovering there is no memory for events during the dissociative state. See Dissociative Fugue (Pg. 170).

Recovered Memory – *Cognitive Disorder Not Otherwise Specified*
A memory, usually for a traumatic event or experience, such as being sexually abused as a child, retrieved after having been forgotten or repressed, often for many years. Unless it is verified, what appears to be a recovered memory may in fact be a False Memory.
Reduplicative Paramnesia – Amnestic
A disorder of memory in which a person may believe that familiar objects such as buildings are not the ones he or she knows, but merely resemble them.

Source Amnesia – Amnestic
A form of Amnesia in which information is remembered, but the person who remembers it is unable to recall where, from whom, or how the information was obtained.

Stockholm Syndrome – Other Cognitive Disorders
A psychological condition in which hostages or victims of kidnaping sometimes develop positive feelings towards their captors, on whom they depend for their survival, especially after being released. Named after a siege in the Swedish capital Stockholm in 1973 in which people were taken hostage by bank robbers and later refused to cooperate with police.

Transient Global Amnesia – Amnestic
A sudden loss of memory, including both Anterograde Amnesia and Retrograde Amnesia, with full recovery within 24 hours, often resulting from ischaemia in the hippocampus or fornix.
Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence

Individuals with Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence have mental disorders that begin in early childhood. It should be noted that other psychiatric disorders may occur in childhood. Additionally, some of the childhood disorders may persist into adulthood.

Disorders in this Category

Attention Deficit and Disruptive Behavior Disorders
- Attention-Deficit/Hyperactivity Disorder (Code – None)
- Attention-Deficit/Hyperactivity Disorder Not Otherwise Specified (Code – 314.9)
- Ballism (Code – None)
- Conduct Disorder (Code – None)
- Disruptive Behavior Disorder Not Otherwise Specified (Code – 312.9)
- Hyperkinesis Disorder (Code – None)
- Hyperkinetic Disorder (Code – None)
- Oppositional Defiant Disorder (Code – 313.81)
- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (Code – None)

Communication Disorders
- Communication Disorder Not Otherwise Specified (Code – 307.9)
- Developmental Articulation Disorder (Code – None)
- Expressive Language Disorder (Code – 315.31)
- Mixed Receptive-Expressive Language Disorder (Code – 315.31)
- Phonological Disorder (Code – 315.39)
- Receptive Language Disorder (Code – None)

Elimination Disorders
- Encopresis (Code – None)
- Enuresis (Code – 307.6.0)

Feeding and Eating Disorders of Infancy or Early Childhood
- Coprophagia (Code – None)
- Feeding Disorder of Infancy or Early Childhood (Code – 307.59)
- Geophagia (Code – None)
- Hyalophagia (Code – None)
- Pagophagia (Code – None)
- Pica (Code – 307.52)
- Rumination (Code – 307.53)

Learning Disorders
- Academic Skills Disorder (Code – None)
- Acalculia (Code – None)
• Acquired Dyslexia (Code – None)
• Agnosia (Code – None)
• Agraphia (Code – None))
• Ahylognosia (Code – None)
• Alexia (Code – None) (Pg. 342)
• Amorphognosia (Code – None)
• Amorphognosis (Code – None)
• Aphasia (Code – None)
• Attentional Dyslexia (Code – None)
• Autotopagnosia (Code – None)
• Bálint's Syndrome (Code – None)
• Broca's Aphasia (Code – None)
• Callosal Apraxia (Code – None)
• Catalexia (Code – None)
• Central Dyslexias (Code – None)
• Cognitive Neuropsychology (Code – None)
• Conduction Aphasia (Code – None)
• Deep Dyslexia (Code – None)
• Developmental Dyslexia (Code – None)
• Disconnection Syndrome (Code – None)
• Disorder of Written Expression (Code – 315.2)
• Dyscalculia (Code – None)
• Dysgraphia (Code – None)
• Dyslexia (Code – None)
• Dysphonia (Code – None)
• Dystaxia (Code – None)
• Finger Agnosia (Code – None)
• Gait Ataxia (Code – None)
• Gargoylism (Code – None)
• Gerstmann Syndrome (Code – None)
• Hyperlexia (Code – None)
• Learning Disorder Not Otherwise Specified (Code – 315.9)
• Left-Sided Apraxia (Code – None)
• Mathematics Disorder (Code – 315.1)
• Mixed Transcortical Aphasia (Code – None)
• Monosomy X (Code – None)
• Peripheral Dyslexia (Code – None)
• Phonological Dyslexia (Code – None)
• Pseudoataxia (Code – None)
• Reading Disorder (Code – 315.00)
• Sensory Ataxia (Code – 315.00)
• Simultanagnosia (Code – 315.00)
• Smith-Magenis Syndrome (Code – None)
• Specific Disorder of Arithmetic Skills (Code – None)
• Specific Spelling Disorder (Code – None)
• Spelling Dyslexia (Code – None)
• Spelt Ahylagnosia (Code – None)
• Strehposymbolia (Code – None)
• Surface Dyslexia (Code – None)
• Sympathetic Apraxia (Code – None)
• Tactile Aphasia (Code – None)
• Topagnosia (Code – None)
• Topographagnosia (Code – None)
• Transcortical Aphasia (Code – None)
• Transcortical Motor Aphasia (Code – None)
• Transcortical Sensory Aphasia (Code – None)
• Unilateral Limb Apraxia (Code – None)
• Visual Aphasia (Code – None)
• Visual Word-Form Dyslexia (Code – None)
• Wernicke's Aphasia (Code – None)
• Word Blindness (Code – None)
• XXX Syndrome (Code – None)

Mental Retardation
• Borderline Intellectual Functioning (Code – None)
• Cerebral Gigantism (Code – None)
• Cerebral Palsy (Code – None)
• Cretinism (Code – None)
• Cri Du Chat (Code – None)
• Down's Syndrome (Code – None)
• Foetal Alcohol Syndrome (Code – None)
• Fragile X Syndrome (Code – None)
• Hurler's Syndrome (Code – None)
• Klinefelter's Syndrome (Code – None)
• Lesch-Nyhan Syndrome (Code – None)
• Macrocephaly (Code – None)
• Mental Retardation, Severity Unspecified (Code – 319)
• Microcephaly (Code – None)
• Mild Mental Retardation (Code – 317)
• Moderate Mental Retardation (Code – 318.0)
• Monosomy X (Code – None)
• Prader-Willi Syndrome (Code – None)
• Profound Mental Retardation (Code – 318.2)
• Severe Mental Retardation (Code – 318.1)
• Shaken Baby Syndrome (Code – None)
• Sotos Syndrome (Code – None)
• Tay-Sachs Disease (Code – None)
• Trisomy (Code – None)
• Turner's Syndrome (Code – None)
• Williams Syndrome (Code – None)
• XXX Syndrome (Code – None)
• XXY Syndrome (Code – None)

Motor Skills Disorder
• Developmental Coordination Disorder (Code – 315.4)

Other Disorders of Infancy, Childhood, or Adolescence
• Anaclitic Depression (Code – None) (Pg. 342, 313)
• Disorder of Infancy, Childhood, or Adolescence Not Otherwise Specified (Code – 313.9)
• Elective Mutism (Code – None)
• Hospitalism (Code – None)
• Overanxious Disorder (Code – None)
• Reactive Attachment Disorder of Infancy or Early Childhood (Code – 313.89)
• Selective Mutism (Code – 313.23)
• Separation Anxiety Disorder (Code – 309.21)
• Stereotypic Movement Disorder (Code – 307.3.0)

Pervasive Developmental Disorders
• Asperger’s Disorder (Code – 299.80)
• Autistic Disorder (Code – 299.00)
• Childhood Disintegrative Disorder (Code – 299.10)
• Fragile-X Syndrome (Code – None)
• Heller’s Syndrome (Code – None)
• Idiot Savant (Code – None)
• Infantile Autism (Code – None)
• Kanner’s Syndrome (Code – None)
• Mongolism (Code – None)
• Pervasive Development Disorder Not Otherwise Specified (Code – 299.80)
• Rett’s Disorder (Code – 299.80)
• Williams Syndrome (Code – None)

Tic Disorders
• Chronic Motor or Vocal Tic Disorder (Code – 307.22)
• Coprolalia (Code – None)
• Copropraxia (Code – None)
• Echolalia (Code – None)
• Palilalia (Code – None)
• Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (Code – None)
• Tic Disorder Not Otherwise Specified (Code – 307.20)
• Tourette’s Disorder (Code – 307.23)
• Transient Tic Disorder (Code – 307.21)
Internet Resources
http://cwresource.org/hotTopics/mentalHealth1/disorders.htm
http://www.geocities.com/morrison94/child.htm
http://www.hon.ch/HONselect/Selection/F03.550.html
http://www.use.hcn.com.au/subject.%60Mental%20Disorders%20Diagnosed%20in%20Childhood%60/home.html

Movie Suggestions
- All the Little Animals
- Antonia's Line
- Backstreet Dreams
- Being There
- Best Little Girl in the World, The
- Best Boy
- Bill, On His Own
- Bill
- Boy Who Could Fly, The
- Carrie
- Charly
- Charley
- Child Is Waiting, A
- Clockwork Orange, A
- Cries from the Heart
- Dangerous Woman, A
- Day in the Life of Joe Eff, A
- Dodes’ ka-den
- Dominick and Eugene
- Equus
- Every Man for Himself and God Against All
- Face to Face
- Fanny and Alexander
- Forbidden Games
- Forrest Gump
- Four Hundred Blows, The
- Heart Is a Lonely Hunter, The
- Homer and Eddie
- House of Cards
- I Stand Alone
- I Am Sam
- Innocents, The
- Kids
- Larry
- Last Great Disgrace, The
- Leolo
- Little Voice
- Little Man Tate
- Lord of the Flies
- Mercury Rising
- Mifune
- Molly
- Motor Skills Disorder
- Nell
- Niagara, Niagara
- Of Mice and Men
- On the Waterfront
- Other Sister, The
- Pelle the Conqueror
- Pixote
- Rain Man
- Rebel Without A Cause
- Salaam Bombay!
- Shower, The
- Simple Plan, A
- Sling Blade
- Splendor in the Grass
- The Young and the Damned
- Tic Code, The
- Tim
- Time
- Tin Drum, The
- To Kill a Mockingbird
- Tree Grows in Brooklyn, A
- Unforgotten: 25 Years After Willowbrook
- Welcome to the Dollhouse
- What's Eating Gilbert Grape?
- Wild Flower
- Wild Child, The
- Wish You Were Here
- Wizard, The
- Young Poisoner's Handbook, The
- Young and the Damned, The
Additional Disorders

**Academic Skills Disorders – Learning Disorders**
Students with Academic Skills Disorders are often years behind their classmates in developing reading, writing, or arithmetic skills. The diagnoses in this category include: Developmental Reading Disorder, Developmental Writing Disorder, and Developmental Arithmetic Disorder.

**Acalculia – Learning Disorders**
Impairment of ability to do arithmetic.
- From Greek – \(-a-, \text{ without} + \text{Latin} – \text{calculare, to count; from calculus diminutive of calx, a stone} + -\text{ia, indicating a condition or quality}\)

**Acquired Dyslexia – Learning Disorders**
One of the two major categories of Dyslexia; this form of the disorder results directly from brain damage, usually to the left cerebral hemisphere.
- From Greek – \(-\text{dys-, bad or abnormal} + \text{lexis, a word} + -\text{ia, indicating a condition or quality}\)

**Agnosia – Learning Disorders**
A term introduced in 1891 by the Austrian neurologist and founder of psychoanalysis Sigmund Freud (1856–1939), nowadays denoting an impairment of ability to recognize or identify familiar objects, entities, or people, usually as a result of a neurological deficit or disorder. The major forms are: ahylognosia or impaired ability to discriminate by touch such physical properties of objects as their weight, density, or texture (compare amorphagnosia, tactile agnosia); amorphagnosia, an impaired ability to recognize by touch the size and shape of objects (compare ahylognosia); tactile agnosia; anosognosia, an impaired ability or refusal to recognize that one has a sensory or motor impairment or, in some cases following a massive stroke and hemiplegia, even to recognize part of one's body as one's own; apperceptive agnosia, an impaired ability to identify and discriminate between objects, usually associated with right hemisphere brain damage, also called visual shape agnosia (in contrast to associative agnosia); asomatognosia, an impaired ability to recognize one's own body or part of it (compare anosognosia, autotopagnosia); associative agnosia, an impaired ability to interpret or give meaning to objects, as in failing to understand that a 4-inch-long hollow cylinder, closed at one end, with a loop attached to the outside, is a mug (in contrast to apperceptive agnosia); auditory agnosia, an impaired ability to recognize or identify familiar sounds or spoken words; autotopagnosia, an impaired ability to identify parts of one's own body, often indicative of lesions in the pathway between the thalamus and the parietal lobes (compare asomatognosia, finger agnosia, topagnosia); color agnosia, an impaired ability to recognize or identify colors in spite of intact color discrimination and adequate language skills (compare achromatopsia); finger agnosia an impaired ability to recognize, identify, differentiate, name, select, or indicate individual fingers of either hand, hence a form of autotopagnosia; gustatory agnosia, an impaired ability to recognize or identify tastes; haptic agnosia, another name for tactile agnosia; horologagnosia, an impaired ability to tell the time; integrative agnosia, with intact ability to recognize elements of perceptual
forms and impaired ability to integrate the elements into perceptual wholes; logagnosia, another name for Wernicke's aphasia (see under aphasia); object blindness, an impaired ability to identify objects that are clearly perceived; olfactory agnosia, an impaired ability to recognize or identify smells; optic agnosia, an impaired ability to identify objects by sight, with intact ability to identify them by touch; phonagnosia, an impaired ability to identify people by their voices; prosopagnosia, an impaired ability to recognize or identify previously familiar faces, sometimes even those of close relatives, such faces being identified as faces, but not as belonging to particular known people, this form of agnosia usually being associated with damage to the posterior right hemisphere; simultanagnosia, an impaired ability to perceive more than one object at the same time, often occurring as a symptom of Bálint's syndrome; tactile agnosia, an impaired ability to recognize or identify objects by touch alone, also called haptic agnosia, tactoagnosia (compare ahylognosia, amorphognosia); topagnosia, an impaired ability to identify which part of one's body has been touched (compare autotopagnosia); topographagnosia an impaired ability to find one's way around, read maps, draw plans, and perform similar tasks, often associated with damage to the right hemisphere parietal lobe, comparable to visuospatial agnosia (see also separate entry); transformational agnosia, an impaired ability to recognize objects viewed from unusual angles, such as a tennis racket seen from its side, based on the assumption that the impairment derives from a deficit in the ability to transform the major or minor axis—length or width—when it appears foreshortened, often associated with damage to the right parietal lobe, and also called apperceptive agnosia; visual agnosia, an impaired ability to recognize or identify visual images or stimuli; visual shape agnosia an impaired ability to identify and discriminate between objects, usually associated with right hemisphere brain damage, also called visual apperceptive agnosia (in contrast to associative agnosia); visuospatial agnosia, an impaired ability to count a small number of scattered objects, coupled with peculiar alignment of handwriting, such as confining the words to only one half of a page, impairment in reading ability, impaired ability to copy simple drawings, often associated with damage to the right hemisphere at the junction of the occipital and parietal lobes, also called acatamathesia.

From Greek – a-, without + gnosis, knowledge + -ia, indicating a condition or quality

Agraphia – Learning Disorders
An impairment in the ability to write, resulting from neurological damage to the language centers in the brain. The major forms are: apraxic agraphia, an impaired ability to write in spite of an ability to spell words orally; agraphia for numbers, an impaired ability to write numbers, also called agraphic acalculia; ideational agraphia, an impaired ability to select appropriate letter forms in spite of an ability to copy written text; orthographical agraphia, an impaired ability to translate spoken sounds into appropriate written forms, also called lexical agraphia; phonological agraphia, an impaired ability to spell by sound, coupled with over-reliance on established spelling vocabulary; spatial agraphia an impaired ability to arrange and orient writing appropriately on a page; surface agraphia, spelling by sound coupled with an impaired ability to spell irregular words.

From Greek – a-, without + graphein, to write + -ia, indicating a condition or quality.

Ahylognosia – Learning Disorders
Impaired ability to discriminate by touch such physical properties as weight, density, or texture, with intact ability to recognize size and shape. Also called Spelt Ahylagnosia.

- From Greek – *a-* without + *hyle*, matter + *gnosis*, knowledge + *-ia*, indicating a condition or quality.

**Alexia** – *Learning Disorders*

An inability to read written or printed words, usually called Dyslexia. Also called Visual Aphasia (Pg. 350) or (non-technically) Word Blindness.

- From Greek – *a-* without + *lexis*, a word + *-ia*, indicating a condition or quality.

**Amorphognosia** – *Learning Disorders*

Impaired ability to recognize by touch the size and shape of objects. See Also called Amorphognosis.

- From Greek – *a-* without + *morphe*, form + *gnosis*, knowledge + *-ia*, indicating a condition or quality.

**Amorphognosis** – *Learning Disorders*

See Amorphognosia (Pg. 342).

**Anaclitic Depression** – *Other Disorders of Infancy, Childhood, or Adolescence*

A form of Depression manifested by infants, usually triggered by sudden separation from a parent after having had a normal relationship for at least six months, characterized by crying, apprehension, withdrawal, anorexia, and dyssomnias. The disorder was introduced and named in 1946 by the Austrian psychoanalyst René A. Spitz (1887–1974).

**Aphasia** – *Learning Disorders*

An impairment of expression or comprehension of language caused by injury or disease in the language centers of the brain. The major forms related specifically to speech are: acoustic-mnestic aphasia, an impaired ability to recall lists of words or to repeat long sentences, caused by a lesion in the left temporal lobe of the brain; agrammatism, an impairment in the ability to arrange words in their correct order, to use function words properly, and/or to use accidence appropriately in an inflecting language; amnesic aphasia, an impaired ability to retrieve words that are required for fluent speech, also written amnestic aphasia; anomic aphasia, an impaired ability to name objects or representations of objects, also called anoma (compare amnesic aphasia); aphemia, another name for Broca's aphasia; ataxic aphasia, another name for Broca's aphasia; auditory aphasia, another name for Wernicke's aphasia; Broca's aphasia, an impaired ability to speak, with intact ability to comprehend speech, associated with damage to Broca's area of the brain; conduction aphasia, an impaired ability to repeat spoken words, together with errors in word selection in spontaneous speech, resulting from damage to the links between auditory and motor areas of the brain (compare mixed transcortical aphasia, transcortical motor aphasia, transcortical sensory aphasia; see also arcuate fasciculus); dynamic aphasia, a variant of non-fluent aphasia characterized by almost total failure to initiate speech, but an intact ability to name objects, to read, and to repeat sentences; dysprosody, an impaired ability to produce the appropriate prosody required in speech; expressive aphasia, another name for Broca's aphasia; fluent aphasia, which is
any form of aphasia, such as Wernicke's aphasia or conduction aphasia, in which speech flows without difficulty, but either language comprehension is impaired or the speech is unintelligible; ideomotor aphasia, a generic term for transcortical motor aphasia, transcortical sensory aphasia, and mixed transcortical aphasia; jargon aphasia, or copious unintelligible speech; laloplegia, a form of aphasia resulting from paralysis of the muscles of the vocal tract and not those of the tongue; mixed transcortical aphasia, a blend of transcortical motor aphasia and transcortical sensory aphasia, with impaired spontaneous speech, but intact ability to repeat spoken language (compare conduction aphasia); motor aphasia, another name for Broca's aphasia; nominal aphasia, a form of amnesic aphasia in which there is an impaired ability to retrieve the names of people or things; non-fluent aphasia, or any form of aphasia, such as Broca's aphasia, in which speech is impaired; optic aphasia, which involves selective impairment in ability to name objects presented visually, with intact ability to name them after touching them; paraphasia, the habitual substitution of one word for another; receptive aphasia, another name for Wernicke's aphasia; sensory aphasia, another name for Wernicke's aphasia; spasmophemia, characterized by speech that is impaired by spasms of the muscles in the vocal tract; standard aphasia, or sparse speech with content words, but few function words; syntactic aphasia, an impaired ability to arrange words in grammatical sequence; tactile aphasia, the selective impairment in ability to name objects by touch alone, with intact ability to name them after seeing them; transcortical motor aphasia, or any form of aphasia resulting from disconnection of fiber tracts across the cortex to motor areas, resulting in impaired spontaneous speech, but intact ability to repeat spoken language (compare conduction aphasia); transcortical sensory aphasia, or any form of aphasia resulting from disconnection of fiber tracts across the cortex to sensory areas, resulting in impaired spontaneous speech, but intact ability to repeat spoken language (compare conduction aphasia); visual aphasia, another name for alexia; Wernicke's aphasia, an impaired ability to understand speech, with intact ability to speak fluently, though not always intelligibly, associated with damage to Wernicke's area in the brain.

From Greek – *a*-, without + *phasis*, speech; from *phanai*, to speak + *-ia*, indicating a condition or quality.

**Athetosis** – *Attention Deficit and Disruptive Behavior Disorders*

A writhing involuntary movement especially affecting the hands, face, and tongue. It is usually a form of cerebral palsy. It impairs the child's ability to speak or use his or her hands; intelligence is often unaffected. Such movements may also be caused by drugs used to treat Parkinsonism or by the withdrawal of phenothiazines.

**Attentional Dyslexia** – *Learning Disorders*

A rare form of Dyslexia, characterized by normal reading of individual words and naming of individual letters presented in isolation, but an impaired ability to read more than one word or to name more than one letter when two or more are presented simultaneously on the page.

**Autotopagnosia** – *Learning Disorders*
A form of agnosia involving an impaired ability to identify parts of one’s own body, often indicative of a lesion in the pathway between the thalamus and the parietal lobe. Often misspelled autopagnosia.

■ From Greek – *autos*, self + *topos*, place + *a-*, without + *gnosis*, knowing + *-ia*, indicating a condition or quality.

Bálint's Syndrome – *Learning Disorders*
A syndrome caused by bilateral brain damage in the area where the parietal and occipital lobes meet, characterized by Optic Ataxia; Ocular Apraxia, an inability to shift gaze on command; and Simultanagnosia. Named after the Hungarian physician Rezsoe Bálint (1874–1929) who first described it in 1907.

Ballism—*Attention Deficit and Disruptive Behavior Disorders*
A condition usually resulting from damage to the subthalamic nucleus characterized by involuntary violent flailing of the limbs, resembling throwing movements, which are exhausting and incapacitating.

■ From Greek – *ballein*, to throw

Broca's Aphasia – *Learning Disorders*
See Aphasia (Pg. 340).

Callosal Apraxia – *Learning Disorders*
See Left-Sided Apraxia (Pg. 350).

Catalexia – *Learning Disorders*
A form of Dyslexia in which the same word or phrase is read repeatedly.

■ From Greek – *kata*, down + *lexis*, a word + *-ia*, indicating a condition or quality.

Central Dyslexias – *Learning Disorders*
A general term for forms of Dyslexia that are thought to depend on cognitive processing operations occurring in the central nervous system after the words have been visually analyzed. One major subtype of Central Dyslexias is Surface Dyslexia; another is Deep Dyslexia.

Cerebral Palsy – *Mental Retardation*
A form of congenital paralysis with muscular discoordination, caused by brain injury during birth, viral infection, or lack of oxygen in the brain before, during, or immediately after birth, often associated with some degree of Mental Retardation.

Cerebral Gigantism – *Mental Retardation*
A congenital disorder characterized by large size and weight at birth, accelerated growth in infancy and childhood, acromegalic features, and neurological disorder usually accompanied by moderate Mental Retardation. Also called Sotos Syndrome, after the U.S. pediatrician Juan Fernandez Sotos (b. 1927) who, with four colleagues, first described it in 1964.
Cognitive Neuropsychology – *Learning Disorders*

The study of deficits or impairments in human cognitive function resulting from brain damage. Alongside cognitive psychology and artificial intelligence, it is one of the three main approaches to cognition and has been especially fruitful in research into processes such as reading and writing. For example, it has established that different routes exist for translating written words into speech, because some brain-damaged patients with surface Dyslexia are able to read only by translating each letter into its corresponding sound and have great difficulty with orthographically irregular words like yacht, whereas others with Deep Dyslexia or Phonological Dyslexia can read only by whole-word recognition and have difficulty with simple non-words like bink, because they cannot translate letters into sounds.

Conduction Aphasia – *Learning Disorders*

See Aphasia (Pg. 342).

Coprolalia – *Tic Disorders*

Repetitive or obsessive obscene utterances, such as sometimes occurs in Tourette's disorder.

- From Greek – *kopros*, excrement + *lalia*, speech + -ia, indicating a condition or quality.

Coprophagia – *Feeding and Eating Disorders of Infancy or Early Childhood.*

Eating of excrement or feces.

- From Greek – *kopros*, excrement + *phagein*, to consume + -ia, indicating a condition or quality.

Copropraxia – *Tic Disorders*

Compulsive or repetitive obscene gestures such as sometimes occur in Tourette's disorder.

- From Greek – *kopros*, excrement + *praxis*, a deed or action; from *prassein*, to do + -ia, indicating a condition or quality.

Cretinism – *Mental Retardation*

A congenital deficiency of thyroxine, the thyroid hormone, resulting in arrested physical development and Mental Retardation if untreated.

- From French – *crétin*; from Latin – *Christanus*, Christian, here meaning “human,” referring to the fact that such afflicted people are not animals.

Cri Du Chat – *Mental Retardation*

A rare congenital condition caused by a partial deletion of chromosome 5, resulting in Mental Retardation.

Deep Dyslexia – *Learning Disorders*

A form of Dyslexia characterized by inability to read non-words (such as kebby), semantic errors, and impairment in reading abstract rather than concrete words; reading by relying on an established vocabulary of words that are recognized by sight. A person
with deep Dyslexia may misread drink as beer or country as nation and may also make visual errors such as reading single as signal.

Developmental Dyslexia – Learning Disorders
One of the two major categories of Dyslexia; forms of the disorder that develop during childhood from unknown causes, also called Reading Disorder.

Developmental Articulation Disorder – Communication Disorders
See Phonological Disorder

Disconnection Syndrome – Learning Disorders
A term coined in 1965 by the U.S. neurologist Norman Geschwind (1926–84) for a condition in which information transfer between parts of the brain is interrupted or blocked.

Down's Syndrome – Mental Retardation
A disorder linked to a chromosomal abnormality resulting in a broadened and flattened face and nose, short, stubby fingers, skin folds at the edges of the eyes, Mental Retardation, and the premature development of Alzheimer's disease, usually in middle age. Formerly called Mongolism. Named after the English psychiatrist John Langdon Haydon Down (1828–96) who first described this condition.

Dyscalculia – Learning Disorders
Impairment in ability to do arithmetic.
- From Greek – dys-, bad or abnormal + Latin – calculare, to count; from calculus diminutive of calx, a stone + -ia indicating a condition or quality.

Dysgraphia – Learning Disorders
Inability to write correctly, resulting from a neurological or other disorder.
- From Greek – dys-, bad or abnormal + graphein, to write + -ia, indicating a condition or quality.

Dyslexia – Learning Disorders
Impairment in ability to read, not resulting from low intelligence. It was first described in 1877 by the German physician Adolf Kussmaul (1822–1902), who coined the term “word blindness” to refer to it.
- From Greek – dys-, bad or abnormal + lexis, a word + -ia, indicating a condition or quality

Dysphonia – Learning Disorders
Inability to speak normally, resulting from impairment of voice quality, such as hoarseness or strain of the vocal cords.
- From Greek – dys-, bad or abnormal + phone voice or sound + -ia, indicating a condition or quality.
Dystaxia – *Learning Disorders*
Partial Ataxia.
- From Greek – *dys-*, bad or abnormal + *taxis* order + *-ia*, indicating a condition or quality.

Echolalia – *Tic Disorders*
A pathological parrot-like repetition of overheard words or speech fragments, often with a mocking intonation, symptomatic of some mental disorders, including Catatonic, Schizophrenia, Latah, Piblokoq, and some Tic Disorders.
- From Greek – *echo*, a sound + *lalia*, speech.

Echopraxia – *Tic Disorders*
Automatic or uncontrollable imitation of other people's movements, gestures, or postures, symptomatic of some mental disorders, including Catatonic, Schizophrenia, Latah, and Piblokoq.
- From Greek – *echo*, a sound + *praxis*, a deed or action + *-ia*, indicating a condition or quality.

Elective Mutism – *Other Disorders of Infancy, Childhood, or Adolescence*
A mental disorder of childhood or adolescence whose essential feature is a persistent failure to speak in certain social situations in which speaking is expected, such as at school or among peers, despite a proven ability to speak in other situations. To satisfy the diagnostic criteria, the behavior must interfere with educational or occupational achievement or with social interaction and must not be attributable to a lack of knowledge or facility with the language required in the specified situations, or to embarrassment about a communication disorder such as stuttering.
- From Latin – *mutus*, dumb.

Fetal Alcohol Syndrome – *Mental Retardation*
See Foetal Alcohol Syndrome

Finger Agnosia – *Learning Disorders*
A form of Autotopagnosia usually associated with a lesion in the posterior region of the dominant hemisphere, and characterized by a primary inability to recognize, identify, differentiate, name, select, or indicate individual fingers of either hand. If a person with finger agnosia is touched on either one or two fingers, each finger being touched in either one or two places, such a person is unable to state how many fingers are being touched.

Foetal Alcohol Syndrome – *Mental Retardation*
A highly variable pattern of congenital defects, including small stature, Mental Retardation, pixie-like facial features, and malformations of the skull and brain that tend to occur in infants of mothers who drink large quantities of alcohol during pregnancy. More commonly spelled Fetal Alcohol Syndrome.

Fragile-X Syndrome – *Pervasive Developmental Disorders*
A major genetic disorder caused by an abnormality in an X chromosome. The Fragile-X Syndrome is second only to Down's Syndrome as a cause of Mental Retardation. It
predominantly affects males, but about one-third of the females with this mutation on one of their two X chromosomes are also mentally retarded. The most common inherited cause of Mental Retardation, involving an easily damaged X chromosome with a tip hanging by a narrow thread; the syndrome is often accompanied by Attention-Deficit/Hyperactivity Disorder, with additional characteristics such as enlarged head, long face, prominent ears, and in males, enlarged testicles.

Gait Ataxia – Learning Disorders
A form of Ataxia caused by a lesion in the anterior lobe of the cerebellum, usually as a consequence of Alcohol Dependence, characterized by staggering movement even when sober and inability to stand still with feet together.

Gargoylism – Learning Disorders
See Gait Ataxia (Pg. 348), Hurler’s Syndrome (Pg. 348).

Geophagia – Feeding and Eating Disorders of Infancy or Early Childhood
A form of Pica characterized by the eating of earth or dirt.
- From Greek – ge, earth + phagein, to consume + -ia, indicating a condition or quality.

Gerstmann Syndrome – Learning Disorders
A neurological disorder characterized by left-right disorientation, Agraphia, Acalculia, and Finger Agnosia, generally associated with lesions in the parietal lobe of the dominant cerebral hemisphere. Named after the Austrian neurologist Josef Gerstmann (1887–1969) who first noticed in 1930 the tendency for the four components of the syndrome to occur together.

Heller’s Syndrome – Pervasive Developmental Disorders
An alternative name for Childhood Disintegrative Disorder. Named after the Austrian neuropsychiatrist Theodor O. Heller (1869–1938) who first described it and called it Dementia Intantalis in 1908.

Hospitalism – Other Disorders of Infancy, Childhood, or Adolescence
A term introduced in 1945 by the Austrian psychoanalyst René A. Spitz (1887–1974) to denote the physical and psychological effects on an infant (up to 18 months old) of prolonged and total separation from its mother due to hospitalization or some other similar cause. According to Spitz, the characteristics include retarded physical development and disruption of perceptual-motor skills and language.

Hurler’s Syndrome – Mental Retardation
A hereditary metabolic disorder transmitted by a recessive gene resulting in the absence of an enzyme and leading to severe Mental Retardation, swelling of the liver and spleen, low forehead, enlarged head, often clouding of the corneas of the eyes, and usually death during childhood from heart or lung complications. Also called Gargoylism. Named after the German pediatrician Gertrud Hurler (1889–1965) who first described it in 1919.
Hyalophagia – *Feeding and Eating Disorders of Infancy or Early Childhood*
A form of Pica characterized by eating glass.
- From Greek – *hyalos*, glass + *phagein*, to consume + -ia, indicating a condition or quality.

Hyperkinetic Disorder – *Attention Deficit and Disruptive Behavior Disorders*
Excessive movement, as in such conditions as Athetosis or Ballism, or in Hyperkinetic Disorders and in children.
- From Greek – *hyper* over + *kinesis*, movement.

Hyperkinetic Disorder – *Attention Deficit and Disruptive Behavior Disorders*
A class of disorders with early onset (in the first five years of life) characterized by persistent inattention and lack of persistence in activities requiring concentration, together with excessive, disorganized, and unregulated physical activity or hyperkinesis, and often impulsivity, recklessness, and accident-proneness.

Hyperlexia – *Learning Disorders*
A Reading Disorder characterized by advanced word-recognition skills in a person with pronounced cognitive and language deficits. People with Hyperlexia manifest word-recognition skills by their ability to pronounce single words presented to them out of context, but they lack the ability to understand printed words and texts and therefore have poor reading comprehension. The condition was first identified and named by Norman E. Silberberg and Margaret C. Silberberg in 1967.
- From Greek – *hyper* over + *lexis* a word + -ia indicating a condition or quality.

Idiot Savant -- *Pervasive Developmental Disorders*
A person with Mental Retardation who can perform at a high level in some restricted domain of intellectual functioning, such as memorizing vast bodies of information, musical or artistic performance, or calendar calculating—naming the day of the week for a specified date in the past or future. It is not unusual for an idiot savant to suffer from Autistic Disorder.
- From French – *idiot*, an idiot + *savant*, wise or knowledgeable.

Infantile Autism – *Other Disorders of Infancy, Childhood, or Adolescence*
See Autistic Disorder (Pg. 122).

Kanner's Syndrome – *Pervasive Developmental Disorders*

Klinefelter's Syndrome – *Mental Retardation*
A disorder of males resulting from the presence of two or more X chromosomes, causing small testicles, female physical characteristics, long legs, and Mental Retardation. Also called XXY Syndrome. Named after the U.S. physician Harry Fitch Klinefelter (b. 1912) who first described it in 1942.
Landau Kleffner Syndrome – *Communication Disorders*
Also known as LKS. A rare form of childhood epilepsy which results in a severe Language Disorder. The cause of the condition is unknown. All children with LKS have abnormal electrical activity in one, sometimes both temporal lobes, the area of the brain responsible among other functions for processing language. This epileptiform activity shows up in an EEG test particularly when the child is asleep. About two-thirds of LKS children have seizures. Seizures during the night are common. Many children have very few seizures and these are readily controlled by anti-epileptic drugs. Some children never have obvious seizures: it is not necessary to have a seizure to have LKS. A few children have many seizures which are harder to control.

Left-Sided Apraxia – *Learning Disorders*
An impairment of ability to carry out verbal requests with the left hand, resulting from damage to the corpus callosum, preventing impulses from the left hemisphere, where language is processed, from reaching the right motor cortex, where control of the left side of the body is located. Also called Callosal Apraxia, Sympathetic Apraxia, and Unilateral Limb Apraxia.

Lesch-Nyhan Syndrome – *Mental Retardation*
A hereditary disorder of purine metabolism, affecting young boys, transmitted by a sex-linked recessive gene, characterized by Mental Retardation self-mutilation of lips and fingers by biting, and abnormal physical development, often leading to death. Named after the U.S. pediatricians Michael Lesch (b. 1939) and William L. Nyhan, Jr. (b. 1926), who first studied this condition.

Macrocephaly – *Mental Retardation*
Congenital enlargement of the head without increased intracranial pressure resulting in some degree of Mental Retardation.
- From Greek *makros*, large + *kephale*, head.

Maternal Deprivation – *Other Disorders of Infancy, Childhood, or Adolescence*
The condition said to result if infants are deprived of the opportunity to form a close relationship with a single parental figure, who may or may not be the child's natural parent. It is characterized by distress and Depression, leading to an inability to form lasting relationships.

Microcephaly – *Mental Retardation*
A congenital condition characterized by an abnormally small head and underdeveloped brain, resulting in some degree of Mental Retardation.
- From Greek *mikros*, small + *kephale*, head.
Mongolism – *Pervasive Developmental Disorders*
An obsolete name for Down's Syndrome, referring to the supposed resemblance of people with the disorder to Mongolians, a comparison now considered offensive.

Mixed Transcortical Aphasia – *Learning Disorders*
See Transcortical Aphasia (Pg. 354).

Monosomy X – *Mental Retardation*
See Turner's Syndrome (Pg. 355)

Neglect Dyslexia – *Learning Disorders*
A type of Dyslexia in which either the initial parts of words are misread as in Left Neglect Dyslexia or the terminal parts of words are misread as in Right Neglect Dyslexia, the errors not being simple deletions, but typically guesses of real, though incorrect, words with approximately the right number of letters.

Optic Ataxia – *Learning Disorders*
A form of Ataxia involving a selective inability to integrate information about the position of an object from proprioceptive information about the position of one's hand or arm.
- From Greek – *a-*, without + *taxis*, order + *-ia*, indicating a condition or quality.

Overanxious Disorder – *Other Disorders of Infancy, Childhood, or Adolescence.*
A childhood anxiety disorder, not included in the DSM-IV classification, corresponding to Generalized Anxiety Disorder in adults, in which anxiety is focused on such matters as personal appearance, health, and academic or sporting achievement at school.

Pagophagia – *Feeding and Eating Disorders of Infancy or Early Childhood*
A form of Pica characterized by the eating of ice.
- From Greek – *pagos*, ice + *phagein*, to consume + *-ia*, indicating a condition or quality.

Palilalia – *Tic Disorders*
A speech abnormality symptomatic of some forms of tic disorder and other mental disorders, characterized by repetition of words or speech fragments with a characteristic acceleration during each cluster of repeated speech.
- From Greek – *palin*, back or again + *lalia*, speech.

Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections
Over the last ten years, there has appeared a mounting body of evidence that suggests there is a small subgroup of individuals whose childhood onset Obsessive-Compulsive Disorder may have been triggered by streptococcal throat infections. This association of an infectious cause with a neurobiological disorder may also be true for *Tic Disorders,*
Trichotillomania, and possibly Attention Deficit/Hyperactivity Disorder. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections is referred to as PANDAS.

Peripheral Dyslexia – Learning Disorders
Another name for visual Word-Form Dyslexia.

Phonological Dyslexia – Learning Disorders
A form of Dyslexia involving an impaired ability to read by using spelling-to-sound correspondences, and an over-reliance on established spelling vocabulary. Closely related to Deep Dyslexia.

Pseudoataxia – Learning Disorders
Loss of ability to coordinate voluntary movements without any lesion in the central nervous system.

From Greek – pseudes, false + a-, without + taxis, order + -ia, indicating a condition or quality.

Receptive Language Disorder – Communication Disorders
A specific developmental disorder characterized by language comprehension substantially below that of expressive language ability and nonverbal intelligence, the deficit not being due solely to a speech or sensory deficit or a physical impairment.

Sensory Ataxia – Learning Disorders
Any form of Ataxia caused by an impairment of sensation, usually proprioception.

Shaken Baby Syndrome – Mental Retardation
A condition characterized by cranial injury, retinal hemorrhage, etc., observed in infants who have been violently jolted.

Simultanagnosia – Learning Disorders
Impaired ability to perceive more than one object or image at the same time, hence an inability to comprehend a whole picture even when its constituent elements can be recognized, often occurring as a symptom of Bálint's Syndrome or a lesion in the left temporal lobe.

Smith-Magenis Syndrome – Learning Disorders
A syndrome characterized by Mental Retardation and multiple congenital anomalies. A deletion at chromosome 17 is seen in most patients by cytogenetics or, in smaller deletion. The deletion occurs in only one chromosome and almost all of the patients have de novo deletions. Smith-Magenis syndrome is characterized by typical craniofacial features, peripheral neuropathy, Mental Retardation, and Attention Deficit/ Hyperactivity Disorder (ADHD). Other typical problems include Onychotillomania, spasmodic upper body squeezing, and sleep behavior. Typically, these patients also have aggression, self-destruction, and tantrums. Renal, musculoskeletal, cardiac, and ophthalmological abnormalities may also be present.
Specific Spelling Disorder – *Learning Disorders*
A specific developmental disorder characterized by a significant impairment in the development of spelling skills without any history of Reading Disorder, the deficit not being attributable to neurological or sensory impairment, Mental Retardation, or environmental deprivation.

Sotos Syndrome – *Mental Retardation*
See Cerebral Gigantism (Pg. 348)

Specific Disorder of Arithmetic Skills – *Learning Disorders*
A specific developmental disorder characterized by a significant impairment in arithmetic skills (addition, subtraction, multiplication, and division) that is not explicable by Mental Retardation or inadequate schooling.

Spelling Dyslexia – *Learning Disorders*
A form of Dyslexia, also called letter-by-letter reading, usually not accompanied by Dysgraphia, in which reading proceeds literally letter by letter and is therefore slow and manifests grave impairment.

Spelt Ahylagnosia.– *Learning Disorders*
See Ahylagnosia (Pg. 342).

Strephosymbolia – *Learning Disorders*
A typical symptom of Dyslexia in which letters are transposed, reversed, or confused; more generally a disorder in which objects are perceived in mirror image.
- From Greek – *strephein*, to twist + *symbolon*, a symbol

Strephosymbolia Hyperlexia – *Learning Disorders*
A Reading Disorder characterized by advanced word-recognition skills in a person with pronounced cognitive and language deficits. People with hyperlexia manifest word-recognition skills by their ability to pronounce single words presented to them out of context, but they lack the ability to understand printed words and texts and therefore have poor reading comprehension. The condition was first identified and named by Norman E. Silberberg and Margaret C. Silberberg in 1967.
- From Greek – *hyper*, over + *lexis*, a word + *-ia*, indicating a condition or quality.

Strephosymbolia – *Learning Disorders*
A typical symptom of Dyslexia in which letters are transposed, reversed, or confused; more generally a disorder in which objects are perceived in mirror image.
- From Greek – *strephein*, to twist + *symbolon*, a symbol.

Surface Dyslexia – *Learning Disorders*
A form of Dyslexia characterized by an over-reliance on spelling-to-sound correspondences, making words whose spelling is irregular (such as debt, busy, and
yacht) difficult or impossible to read. Also called phonological reading, or reading by sound.

Sympathetic Apraxia — Learning Disorders
See Left-Sided Apraxia.

Tactile Aphasia — Learning Disorders
A modality-specific naming impairment in which objects cannot be correctly named on the basis of touch alone so that a pair of scissors may be misnamed as a clock, or a ring as a balloon. This form of aphasia usually results from neurological damage resulting in disconnection between the tactile and language centers of the brain.

Tay-Sachs Disease — Mental Retardation
A hereditary disorder transmitted through a recessive gene, relatively common among Ashkenazi Jews, characterized by progressive accumulation of lipids in the brain, leading to blindness, convulsions, Mental Retardation, and death, usually before 5 years of age. Also called Amaurotic Familial Idiocy. Named after the English ophthalmologist Warren Tay (1843–1927) who first identified it in 1881 and the U.S. neurologist Bernard Sachs (1858–1944) and described it further.

Topagnosia — Learning Disorders
A form of Agnosia involving an impaired ability to identify which part of one's body has been touched.

- From Greek — topos, a place + gnosis, knowing + -ia, indicating a condition or quality.

Topographagnosia — Learning Disorders
A form of Agnosia involving an inability to find one's way around, read maps, draw plans, and perform similar functions, often associated with damage to the right hemisphere parietal lobe.

Transcortical Sensory Aphasia — Learning Disorders
See Transcortical Aphasia.

Transcortical Motor Aphasia — Learning Disorders
See Transcortical Aphasia.

Transcortical Aphasia — Learning Disorders
A generic term for Transcortical Motor Aphasia, Transcortical Sensory Aphasia, and Mixed Transcortical Aphasia, all of which arise from lesions interfering with the transmission of nerve impulses across the cerebral cortex between the language and motor centers, leading to impairment of spontaneous speech with intact ability to repeat spoken language. Also called ideomotor aphasia.

Trisomy — Mental Retardation
The condition of a human or other diploid organism of having three rather than two chromosomes of a particular type. Autosomal trisomies are often associated with Mental...
Retardation, whereas trisomies of the sex chromosomes have variable psychological effects.

Turner's Syndrome – *Mental Retardation*
A congenital chromosomal aberration in a female who has only one X chromosome, leading to short stature, absence of functioning ovaries, underdeveloped breasts, uterus, and vagina, often moderate Mental Retardation, and various other signs and symptoms. Zygotes with just one Y chromosome are non-viable. Also called Monosomy X. Named after the U.S. physician Henry Hubert Turner (1892–1970) who first described it in 1938.

Unilateral Limb Apraxia – *Learning Disorders*
See *Left-Sided Apraxia* (Pg. 354).

Visual Word-Form Dyslexia – *Learning Disorders*
A generic name for Attentional Dyslexia, Neglect Dyslexia, and Spelling Dyslexia.

Visual Aphasia – *Learning Disorders*
See *Alexia* (Pg. 342).

Wernicke's Aphasia – *Learning Disorders*
See Aphasia (Pg. 342).

Williams Syndrome – *Pervasive Developmental Disorders*
A rare condition (estimated to occur in 1 out of 20,000 births) characterized by delayed physical and mental development, leading to mild Mental Retardation (Pg. 182), coupled with strengths in such areas of functioning as language usage, face recognition, social skills, and musical performance. It was discovered in 1993 that the syndrome is caused by the deletion of the gene that directs the manufacture of elastin, a protein providing strength and elasticity to blood vessels, from one of the two copies of chromosome 7 present in every body cell. People with this syndrome, who are often called Williams people or Williams children, have facial features reminiscent of elves or pixies, hoarse voices, hyperacusis or extreme sensitivity to noise, cardiovascular problems, and elevated levels of calcium in the blood. Named after the New Zealand cardiologist John Cyprian Phipps Williams (born 1922) who first described it in 1961.

Word Blindness – *Learning Disorders*
A non-technical name for Alexia or Dyslexia. It was the original term used by the German physician Adolf Kussmaul (1822–1902), who first described Dyslexia in 1877.

XXX Syndrome – *Communication Disorders*
A chromosomal abnormality in which a woman has three X chromosomes instead of the usual two, leading to deficits in auditory and language comprehension, and usually sterility.

XXY Syndrome – *Mental Retardation*
See *Klinefelter's Syndrome* (Pg. 350).
Dissociative Disorders

Individuals with Dissociative Disorders experience a disruption in consciousness, loss or lapse of memory and identity or perception that may be sudden or gradual, transient or chronic. In all cases, one of the aforementioned is not malfunctioning. The condition usually begins suddenly, may be caused by psychological conflict and, is relatively rare.

**Disorders in this Category**
- Anxiety Hysteria (Code – None)
- Depersonalization Disorder (Code – 300.6)
- Depersonalization Neurosis (Code – None)
- Dissociative Identity Disorder (Code – 300.14)
- Dissociative Fugue (Code – 300.13)
- Dissociative Amnesia (Code – 300.12)
- Dissociative Convulsions (Code – None)
- Dissociative Disorder Not Otherwise Specified (Code – 300.15)
- Dissociative Movement Disorder (Code – None)
- Dissociative Motor Disorders (Code – None)
- Dissociative Stupor (Code – None)
- Dissociative Trance Disorder (Code – None)
- Ganser’s Syndrome (Code – None)
- Motor Dissociative Disorders (Code – None)
- Polyfragmentation (Code – None)
- Possession Trance (Code – None)
- Trance (Code – None)
- Trance and Possession Disorders (Code – None)

**Internet Resources**
- http://www.sidran.org/didbr.html
- http://www.rossinst.com/dddquest.htm
- http://www.nami.org/Content/ContentGroups/Helpline1/Dissociative_Disorders.htm
- http://mentalhealth.about.com/od/dissociative/a/disdords.htm

**Movie Suggestions**
- 3 Women
- Agnes of God
- Altered States
- Amateur
- Anastasia
- Black Friday
- Born Identity
- Boston Strangler, The
- Case of Becky, The
- Color of Night
- Cyrano de Bergerac
- Dance of Fire
- Dark Mirror, The
- Dead Again
- Despair
- Devils, The
- Double Life of Veronique, The
- Double Life, A
- Dr. Jekyll and Mr. Hyde
- Dressed to Kill
• Exorcist, The
• Fight Club
• Freud
• Great Dictator
• Gulliver’s Travels
• Hannah and Her Sisters
• Home of the Brave
• Last Temptation of Christ, The
• Long Kiss Goodnight
• Lizzie
• Loose Cannons
• Manchurian Candidate, The
• Me, Myself & Irene
• Me, Myself and I
• Mirage
• Mister Majestic
• My Girl
• Norma Jean & Marilyn
• Nurse Betty
• Overboard
• Paris, Texas
• Pesona
• Piano, The
• Poison Ivy
• Prelude to a Kiss
• Primal Fear
• Psycho
• Raising Cain
• Return of Marin Guerre, The
• Secret of Dr. Kildare, The
• Send Me No Flowers
• Seventh Veil, The
• Sisters
• Sommersby
• Sorry, Wrong Number
• Spellbound
• Steppenwolf
• Suddenly, Last Summer
• Sullivan’s Travels
• Sybil
• Three Lives of Karen, The
• Three Faces of Eve, The
• Twelve O’Clock High
• Two-Soul Woman, The
• Up in Arms
• Voices Within: The Lives of Truddi Chase
• Whatever Happened to Baby Jane?
Additional Disorders

Anxiety Hysteria
In psychoanalysis, a neurosis with a phobia as its central symptom. The term was introduced in 1908 by the Austrian psychiatrist Wilhelm Stekel (1868–1940) in his book *Nervöse Angstzustände und ihre Behandlung (Neurotic Anxiety States and their Treatment)* specifically to emphasize its structural resemblance to Conversion Hysteria now called Dissociative Disorder.

Dissociative Convulsions
A Dissociative Disorder characterized by sudden spasmodic convulsions resembling those of epilepsy, but not associated with loss of consciousness.

Depersonalization Neurosis
Emotional Dissociative Disorder in which there is loss of contact with your own personal reality accompanied by feelings of unreality and strangeness.

Dissociative Motor Disorders
See Dissociative Movement Disorder.

Dissociative Movement Disorders
Forms of Dissociative Disorders in which there is a partial or complete loss of ability to perform bodily movements that are normally under voluntary control, without any apparent organic disorder, including dissociative forms of Akinesia, Aphonia, Apraxia, Ataxia, Convulsions, Dysarthria, Dyskinesia, and Dysstasia. Also called Dissociative Motor Disorders or Motor Dissociative Disorders.

Dissociative Stupor
Profound diminution or absence of voluntary movement and responsiveness to external stimuli apparently resulting from stress.

Dissociative Trance Disorder
A condition characterized by behavior and experience associated with a trance or a possession trance.

Ganser Syndrome
A condition sometimes classified as a Dissociative Disorder and sometimes as a Factitious Disorder, characterized by the giving of approximate answers to questions, the answers being suggestive of knowledge of the right answers. Thus, on being asked how many legs a dog has, a person with Ganser syndrome may reply either three or five, and Sigbert Ganser labeled this Vorbeireden, literally talking past. Also called Nonsense Syndrome. Named after the German psychiatrist Sigbert J. M. Ganser (1853–1931) who first described it in 1897.
**Circumstantiality**: A speech style that is logical and does not involve loosening of associations, but is difficult to follow because it dwells on irrelevant details and takes an inordinate length of time coming to the point.

**Tangentiality**: Responding to questions obliquely rather than directly, without giving direct answers. Also called Tangential Speech.

**Motor Dissociative Disorders.**
See Dissociative Movement Disorder.

**Polyfragmentation**
The term comes from the root “poly,” meaning “many,” and “fragments.” In Complex Polyfragmentation, the survivor will have not only altered systems, but hundreds or even thousands of fragments, isolated parts of their mind created to do a job, and do it well and unthinkingly. Often the job is one that would be abhorrent to the main personality or presenting system. The further away from core beliefs, the greater usually the dissociation and fragmentation that must occur. In other words, a lot of trauma has to happen to make a person do something that they really don't want to do, and the person has to feel very far away from themselves as well when doing it. Cults will purposely try to create a polyfragmented system for this very reason. The person is more dissociated from him- or herself and is often easier for others to control.

**Possession Trance**
A trance associated with the replacement of one's customary personal identity with a new identity, and a belief that this is caused by the influence of a spirit, deity, power, or other person.
- From Old French – *possesser*, to possess; from Latin – *possidere*, to occupy or inhabit + French – *transe*, trance; from Latin – *transire*, to go across or to die.

**Trance**
An altered state of consciousness, shown by a narrowing of awareness of events in the immediate surroundings, a suspension of the sense of personal identity, and diminution in the range of motor activity and speech. It is characteristic of certain forms of intoxication, some mental disorders, and, controversially, hypnosis.
- French – *transe*, trance; from Latin – *transire*, to go across or to die.

**Trance and Possession Disorders**
See Dissociative Trance Disorder.
Eating Disorders

Those with Eating Disorders are individuals with mental disorders who have eating-related problems. These problems may relate to eating too much, eating in an unhealthy manner, or not eating enough.

Disorders in this Category
- Ana’s (Code – None) (Pg. 361)
- Anorexia Nervosa (Code – 307.1)
- Binge-Eating Disorder (Code – None)
- Bulimia Nervosa (Code – 307.1)
- Eating Disorder Not Otherwise Specified (Code – 307.1)
- Hyperorexia (Code – None)
- Hyperphagia (Code – None)
- Hypothalamic Hyperphagia (Code – None)
- Lateral Hypothalamic Syndrome (Code – None)
- Mia’s (Code – None)
- Prader-Willi Syndrome (Code – None)
- Ventromedial Hypothalamic Syndrome (Code – None)

Internet Resources
http://www.something-fishy.org/
http://www.mirror-mirror.org/eatdis.htm
http://www.edauk.com/
http://www.edreferral.com/
http://www.hedc.org/

Movie Suggestions
- Best Little Girl in the World, The
- Dying to be Thin
- Eating
- Fatso
- For the Love of Nancy
- Girl Interrupted
- Heavy
- Hot Spell
- Hunger Point
- Karen Carpenter Story, The
- Kate’s Secret
- Real Women Have Curves
- Search for Signs of Intelligent Life in the Universe
- Secret between Friends, A
- Sharing the Secret
- Stuart Saves His Family
- Talking With
- Ultimate Betrayal
- What’s Eating Gilbert Grape?
- Woman’s Room
Additional Disorders

Ana’s
Anas are pro-Anorexia believers. They promote Anorexia, an eating disorder in which a person intentionally starves or restricts food intake, despite feeling hungry, in an attempt to attain or maintain a body weight which is below normal. The persons may see themselves as "fat" despite being severely underweight and emaciated.

Dysmorphobia
See Body Dysmorphic Disorder.

Hyperorexia
Excessive appetite; another name for Bulimia. The term is usually restricted to cases in which it is not caused by a brain lesion.
- From Greek – hyper, over + orexis, appetite + -ia, indicating a condition or quality.

Hyperphagia
Compulsive overeating; another name for Bulimia, but usually reserved for cases in which it is caused by a lesion in the medial forebrain bundle, the hypothalamus, or some other part of the brain involved in appetite.
- From Greek – hyper, over + phagein to consume + -ia indicating a condition or quality.

Hypothalamic Hyperphagia
See Ventromedial Hypothalamic Syndrome.

Lateral Hypothalamic Syndrome
A constellation of signs and symptoms including Anorexia, Aphagia, and Adipsia associated with lesions in the lateral hypothalamic feeding centers on both sides of the thalamus.

Mia’s
Individuals who promote and support Bulimia Nervosa behavior, an eating disorder in which a person may eat large quantities of food in a short period of time–binge–and then purge or rid the food from their body by means of self-induced vomiting, laxative or diuretic use, or compulsive exercise. Bulimic behavior may also be present with symptoms of Anorexia Nervosa, when a person spends days, weeks or even longer starving, then finally binge eats. The person may feel guilty for having eaten and feel compelled to purge. Feelings of guilt may be present even before the person eats and may be unrelated to food.

Prader-Willi Syndrome
A congenital condition in which obesity is associated with Mental Retardation and small genitalia; diabetes mellitus frequently develops in affected individuals. A. Prader and H. Willi (20th century), Swiss pediatricians.

Ventromedial Hypothalamic Syndrome
A constellation of signs and symptoms associated with a lesion in both sides of the ventromedial hypothalamus, Hyperphagia, Bulimia Nervosa, and aggression or rage. Also called Hypothalamic Hyperphagia.
Factitious Disorders

General Characteristics
Those with Factitious Disorders are individuals with mental disorders whose physical and psychology symptoms are deliberately produced or feigned for the sole purpose of receiving medical attention from health care professionals. An individual with a Factitious Disorder is different from those who malinger for the purposes of receiving monetary compensation, time off from work, relief from responsibility, etc.

Disorders in this Category
- Factitious Disorder (Code – None)
- Factitious Disorder by Proxy (Code – None)
- Factitious Disorder Not Otherwise Specified (Code – None)
- Ganser’s Syndrome (Code – None)
- Hospital Hopper Syndrome (Code – None)
- Münchausen by Proxy Syndrome (Code – None)
- Hypothalamic Hyperphagia (Code – None)
- Nonsense Syndrome (Code – None)
- Pathomimicry (Code – None)
- Peregrinating Patient (Code – None)
- Prison Psychosis (Code – None)
- Pseudologia Fantastica (Code – None)
- Werther Syndrome (Code – None)

Internet Resources
http://www.psychnet-uk.com/dsm_iv/factitious_disorder.htm
http://www.planetpsych.com/zPsychology_101/Disorders/factitious_disorders.htm
http://www.priory.com/psych/factitious.htm
http://www.healthatoz.com/healthatoz/Atoz/ency/factitious_disorders.jsp
http://www.selfhelpmagazine.com/articles/chronic/factit.html

Movie Suggestions
- Sixth Sense, The
- Adventures of Baron Von Munchausen, The
Additional Disorders

Factitious Disorder by Proxy
A pattern of behavior characterized by intentional feigning of physical or psychological signs or symptoms in another person who is being cared for, without any economic or other external incentive for the behavior, the motive being to procure medical treatment for the person being cared for and thereby to assume a sick role by proxy. According to the British pediatrician (Samuel) Roy (later Sir Roy) Meadow (b. 1933), who was the first to identify the phenomenon and who coined the alternative term Münchausen by Proxy Syndrome (MBPS) in 1977; it is not a psychological disorder, but a form of physical or psychological abuse of children or others being cared for.

Ganser Syndrome
A condition sometimes classified as a dissociative disorder and sometimes as a Factitious Disorder, characterized by the giving of approximate answers to questions, the answers being suggestive of knowledge of the right answers. Thus, on being asked how many legs a dog has, a person with Ganser syndrome may reply either three or five, and Sigbert Ganser labeled this Vorbeireden, literally talking past. Also called Nonsense Syndrome. Named after the German psychiatrist Sigbert J. M. Ganser (1853–1931) who first described it in 1897.

Hospital Hopper Syndrome
A colloquial name for Factitious Disorder.

Münchausen by Proxy Syndrome
Another name for Factitious Disorder by Proxy; named after the disorder Münchausen Syndrome, but not itself a mental disorder or syndrome according to the British pediatrician (Samuel) Roy (later Sir Roy) Meadow (born 1933) who named it in 1977. Also called Munchausen Syndrome by Proxy.

Munchausen Syndrome by Proxy
See Münchausen by Proxy Syndrome (Pg. 364).

Nonsense Syndrome
See Ganser Syndrome (Pg. 364).

Pathomimicry
A less common name for Factitious Disorder or Munchausen Syndrome.
- From Greek – pathos, suffering + mimos a mime.

Peregrinating Patient
See Factitious Disorder by Proxy (Pg. 363).
Prison Psychosis
A misleading name for Ganser Syndrome which is not classified as a psychosis and is not peculiar to prisoners. So called because Ganser's original description of it was based on three prisoners awaiting sentence.

Pseudologia Fantastica
A syndrome characterized by habitual telling of implausible lies and fantastic exaggerations, usually half believed by the teller, but often transparently improbable to the recipients. A person with Pseudologia Fantastica; a liar.

- From Greek – *pseudes*, false + *logos*, discourse + *phantastikos*, imaginary; from *phantazein*, to make visible + -*ikos*, of, relating to, or resembling.

Werther Syndrome
A pattern of imitative cluster suicides following the well-publicized suicide of a famous person.
Impulse-Control Disorders

Those with Impulse-Control Disorders are individuals with mental disorders who fail to, or have extreme difficulty, controlling impulses. The impulses typically have negative consequences. The individual feels mounting tension. As the tension increases there is a strong, irresistible need to perform a harmful act against oneself or someone else. Upon completion of the act, the individual feels a sense of gratification, pleasure, and relief. This category may also include such areas as sexual behavior, self-injurious acts, and substance abuse.

Disorders in this Category
- Fire Setting (Code – None)
- Fire Starter (Code – None)
- E-Mail Addiction (Code – None)
- Episodic Dyscontrol Syndrome (Code – None)
- Impulse-Control Disorder Not Otherwise Specified (Code – 312.30)
- Intermittent Explosive Disorder (Code – 312.34)
- Internet Addiction (Code – None)
- Kleptolagnia (Code – None)
- Kleptomania (Code – 312.32)
- Onychotillomania (Code – 312.30)
- Pathological Gambling (Code – 312.31)
- Pyromania (Code – 312.33)
- Road Rage (Code – None)
- Sports Rage (Code – None)
- Trichotillomania (Code – 312.39)
- Ventromedial Hypothalamic Syndrome (Code – None)
- Pathological Computer Use Disorder (Code – None)
- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (Code – None)
- Workaholism (Code – None)

Internet Resources
http://www.psyweb.com/Mdisord/impud.html
http://healthinmind.com/english/impulse.htm
http://www.planetpsych.com/zPsychology_101/Disorders/impulsecontrol_disorders.htm
http://www.psychdirect.com/forensic/Criminology/impulse/impulsecontrol.htm
http://dir.yahoo.com/health/diseases_and_conditions/impulse_control_disorders/

Movie Suggestions
- 29th Street
- American Madness
- Any Number Can Play
- Avalanche, The
- Bad Lieutenant
- Bag of Angels
- Banning
- Barbery Coast
- Basket, The
- Betrayal by a Hand Print
- Big Hand for the Little Lady, A
- Big Gamble, The
- Big Payoff, The
- BINGO!
• Side Out
• Silver Queen
• Smart Money
• Snake Eyes
• Song of the Thin Man
• Sorrowful Jones
• Souls of Sin
• Sour Grapes
• Squeeze, The
• Squibs

• Sting, The
• Stranger Than Paradise
• Strike It Rich
• Suspicion
• Swindle, The
• This Is a Hijack
• To Live
• Two Dollar Bettor
• U-Turn
• UHF

• Underneath, The
• Vegas Vacation
• Vig
• Volunteers
• Wheel of Fate
• White Men Can't Jump
• Who's Got the Action?
• Wine, Women, and Horses
• Winner Take All
• Wise Guys
Additional Disorders

E-Mail Addiction
See Internet Addiction.

Episodic Dyscontrol Syndrome
A rage can occur with little or no provocation or warning. Small changes in the environment can provoke massive repercussions. Some are preceded by a mounting dysphoria that may last for a period of hours or days. The patient may experience olfactory, gustatory, visual, auditory, or multimodal hallucinations before a rage.

Fire Setting
See Pyromania.

Fire Starter
See Pyromania (Pg. 256).

Internet Addiction
A disorder in which people overuse computers to the extent that one or more of the following occur: 1) use causes them distress; 2) use has a detrimental effect on their physical, psychological, interpersonal, marital, economic, or social functioning.

Internet Addiction Syndrome
A condition resembling an impulse-control disorder, first identified in the U.S. in 1994, initially as a joke characterized by excessive or pathological Internet surfing, indicated by such signs and symptoms as being preoccupied with the Internet; recurrent dreams and fantasies about the Internet; lying to family members or therapists to conceal the extent of time spent online; attempting repeatedly and unsuccessfully to cut down or to stop spending time online and becoming restless or irritable while doing so; using the Internet as an escape from worry or unhappiness; and jeopardizing a significant job, relationship, or educational opportunity by spending excessive time online.

Kleptolagnia
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior involving stealing.

 withstand Greek – kleptein, to steal + lagneia, lust.

Onychotillomania
A condition characterized by self-destruction of the fingernails and/or toenails by compulsive manipulation. Onychotillomania may be a form of Obsessive-Compulsive Disorder.

Pathological Computer Use Disorder
See Internet Addiction.
Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections

Over the last ten years, there has appeared a mounting body of evidence that suggests there is a small subgroup of individuals whose childhood onset Obsessive-Compulsive Disorder may have been triggered by streptococcal throat infections. This association of an infectious cause with a neurobiological disorder may also be true for Tic Disorders, Trichotillomania, and possibly Attention-Deficit/Hyperactivity Disorder. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections is referred to as PANDAS.

Road Rage
A grossly disproportional outburst of aggression by the driver of a motor vehicle in response to a perceived discourtesy or transgression by another road user, sometimes indicative of an Intermittent Explosive Disorder or other form of Impulse-Control Disorder.

Sports Rage
A grossly disproportionate outburst of aggression and hostility by sports attendees in response to a moment or play in a sports event where they disagree with the decision or outcome. The aggression may take place against a player, referee, coach, or another sports event attendee. The aggression may lead to violent altercations that end in serious injury and/or permanent disability. The behavior is often consistent with a category of Impulse-Control Disorders known as Intermittent Explosive Disorder. Sports Rage was identified by Gary Solomon, MPH, M.S.W., Ph.D., Professor of Psychology.

Ventromedial Hypothalamic Syndrome
A constellation of signs and symptoms associated with a lesion in both sides of the ventromedial hypothalamus, Hyperphagia, Bulimia Nervosa, and aggression or rage. Also called Hypothalamic Hyperphagia.

Workaholism
The illusion, and associated destructive behaviors caused by that illusion, that a person can effectively address challenges in life and work exclusively by working harder at work. Workaholism has been defined by some as “the pain others applaud.” Many consider it the most respectable of all addictions. Unfortunately the workaholic doesn’t labor in isolation. Other individuals are usually affected, be it spouse, children, or even friends. Financial rewards notwithstanding, the negative impact on others’ lives is quite different from the satisfaction experienced by the worker.
Mental Disorders Due to a General Medical Condition

A Mental Disorder Due to a General Medical Condition is a mental disorder or disorders that may have come about as a direct result of physiological factors leading to psychological problems.

Disorders in this Category
- Akinesia (Code – None)
- Amnestic Disorder Due to a General Medical Condition (Code – 294.0)
- Anxiety Disorder Due to a General Medical Condition (Code – 293.84)
- Aphonia (Code – None)
- Apraxia (Code – None)
- Audiogenic Seizure (Code – None)
- Catatonic Disorder Due to a General Medical Condition (Code – 293.89)
- Clonic Convulsion (Code – None)
- Convulsion (Code – None)
- Delusional Disorder Due to a General Medical Condition (Code – None)
- Dissociative Disorders Due to a General Medical Condition (Code – None)
- Dostoevsky Syndrome (Code – None)
- Dysarthria (Code – None)
- Dyskinesia (Code – None)
- Dysstasia (Code – None)
- Hallucinosis (Code – None)
- Intercital Syndrome (Code – None)
- Mental Disorder Not Otherwise Specified (Code – 293.9)
- Mood Disorder Due to a General Medical Condition (Code – 293.83)
- Organic Disorders (Code – None)
- Personality Change Due to a General Medical Condition (Code – 310.1)
- Postconcussional Disorder (Code – None)
- Postconcussion Syndrome (Code – None)
- Postencephalitic Syndrome (Code – None)
- Psychomotor Epilepsy (Code – None)
- Psychotic Due to a General Medical Condition (Code – 293.8x)
- Psychomotor Seizure (Code – None)
- Seizure (Code – None)
- Sexual Dysfunction Due to a General Medical Condition (Code – None)
- Shaken Baby Syndrome (Code – None)
- Sleep Disorder Due to a General Medical Condition (Code – 780.5x)
- Temporal Lobe Epilepsy (Code – None)
- Temporal Lobe Seizure (Code – None)
- Temporal Lobe Syndrome (Code – None)
Internet Resources
http://www.psychiatry.ufl.edu/addiction/undergraded/course%20material/1.20.pdf
http://www.emedicine.com/med/topic3447.htm
http://www.nurses.info/mental_health_schizophrenia_psychosis_medical.htm
http://psy.psychiatryonline.org/cgi/content/full/41/4/370
http://www.umcpsychiatry.com/medstudents/Psychiatric%20Disorder%20Due%20to%20General%20Medical%20Conditions-Outline.pdf

Movie Suggestions
- 29th Street
- American Madness
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- Avalanche, The
- Bad Lieutenant
- Bag of Angels
- Banning
- Barbery Coast
- Basket, The
- Betrayal by a Hand Print
- Big Hand for the Little Lady, A
- Big Gamble, The
- Big Payoff, The
- BINGO!
- Black Cat, White Cat
- Blondie's Holiday
- Bob Le Flambeur
- Break, The
- Broadway Hostess
- Bronx Tale, A
- Brothers in the Saddle
- Cabin in the Sky
- California Split
- Call of the Canyon
- Canyon Passage
- Casino
- Champ, The
- Cheaters, The
- Cincinnati Kid, The
- Coltrane
- Corrupter, The
- Cosi
- Croupier, The
- Dark Desires: Eva
- Dark Hazard
- Daybreak
- Deadly Bet
- Dear Brigitte
- Death's Marathon
- Deceiver
- Desert Bloom
- Diner
- Dirty Filthy Love
- Disorderlies
- Dona Flor and Her Two Husbands
- Duke of the Deby
- Earrings of Madame De, The
- Easy Come, Easy Go
- Easy Money
- Everybody's All-American
- Face of a Stranger
- Family Prayers
- Fever Pitch
- Follow the Bitch
- Frankie and Johnny
- Frivolous Sal
- Funny Girl
- Gambler, The
- Get Shorty
- Gidley, Tony Lo Bianco
- Gladiator
- Going for Broke
- Great Sinner, The
- Guys and Dolls
- Hard Times
- Hard Eight
- Hardhat and Legs
- Haunting Fear
- Heat
- High Stakes
- Hole in the Head, A
- Hollywood or Bust
- Homestretch, The
- Honeymoon in Vegas
- Hoop Dreams
- House of Games
- House on 56th Street
- Hustler, The
- I Ought to Be in Pictures
- Illegal
- Inside Straight
- Inside Out
- It Happened at the World's Fair
- Joker is Wild, The
- Just the Ticket
- Killing of a Chinese Bookie, The
- Knock on Any Door
- Lady Luck
- Lady Gambles, The
- Las Vegas Story, The
- Last Days of Frankie, The Fly, The
- Let It Ride
- Let's Make It Legal
- Liberty Heights
- Linguini Incident, The
- Little Miss Marker
- Lock, Stock, and Two Smoking Barrels
- Lookin' to Get Out
Lost in America
Mafia!
Making the Grade
Manhattan Melodrama
Marnie
Maverick
Meet Me in Las Vegas
Metro
Michael Shayne: Private Detective
Mississippi Gambler
Money Train
Niagara, Niagara
Now I'll Tell
Odds Against Tomorrow
One Tough Cop
Only Game in Town, The
Oscar and Lucinda
Out to Sea
Parenthood
Phoenix
Pick-up Artist, The
Playing to Win, a Moment of Truth
Please Believe Me

Proposition, The
Queen of Hearts
Queen of Spades
Reindeer Games
Riders of the Range
River Runs Through It, A
Rounders
Rounders
Rover Dangerfield
Rubdown
Runner, The
Seduction of Gina, The
Sgt. Bilko
Shaking the Tree
Shanghais Gesture
Sherlock Holmes and the Spider Woman
Shooting Gallery, The
Side Out
Silver Queen
Smart Money
Snake Eyes
Song of the Thin Man
Sorrowful Jones
Souls of Sin

Sour Grapes
Squeeze, The
Squibs
Sting, The
 Stranger Than Paradise
Strike It Rich
Suspicion
Suspicion
Swindle, The
This Is a Hijack
To Live
Two Dollar Bettor
U-Turn
UHF
Underneath, The
Vegas Vacation
Vig
Volunteers
Wheel of Fate
White Men Can't Jump
Who's Got the Action?
Wine, Women, and Horses
Winner Take All
Wise Guys

Additional Disorders

Akinesia
  A decrease in spontaneous motor activity and a reduction in normal gestures, sometimes caused by a lesion in the supplementary motor area.
  ■ From Greek –  a-, not + kinesis movement + -ia, indicating a condition or quality.

Aphonia
  Loss of the voice resulting from damage to the vocal tract. If the inability to speak is of psychological origin or caused by a lesion in the central nervous system, then the condition is not properly called Aphonia.
  ■ From Greek –  a-, without + phone voice + -ia, indicating a condition or quality.

Apraxia
  A loss or diminution in ability, caused by neurological impairment usually in the left hemisphere of the brain, to perform purposeful bodily movements or gestures on request, though often with apparently unimpaired ability to perform them when they arise in natural contexts, such as when circumstances call for waving goodbye to someone, the
impairment not being due to paralysis or poor comprehension. The major forms are: akinetic apraxia, an impaired ability to perform a spontaneous gesture; amnesic apraxia an impaired ability to perform purposeful bodily movements or gestures on request because of amnesia for the request, also written “amnestic apraxia”; constructional apraxia, an impaired ability to copy simple drawings or patterns; dressing apraxia, an impaired ability to dress; gait apraxia, an impaired ability to walk; ideational apraxia, an impaired ability to repeat previously well-established actions; ideomotor apraxia an impaired ability to imitate unfamiliar actions, also called motor apraxia or ideokinetichapraxia; left-sided apraxia, an impaired ability to carry out verbal requests with the left side of the body, resulting from damage to the corpus callosum preventing impulses from the left hemisphere reaching the right motor cortex, also called callosal apraxia, sympathetic apraxia, and unilateral limb apraxia; oculomotor apraxia, an impaired ability to make eye movements, also called ocular apraxia or optic apraxia; oral apraxia, an impaired ability to perform actions of the mouth and tongue, such as opening the mouth or protruding the tongue; paramimia, an impaired ability to gesture; sensory apraxia, another name for ideational apraxia; speech apraxia, an impaired ability to speak, without other language impairments.

- From Greek – apraxia, inaction; from a-, without + praxis, a deed or action + -ia, indicating a condition or quality.

**Audiogenic**

A convulsion brought about by prolonged exposure to high frequency sounds, especially in rats, mice, hamsters, and rabbits.

- From Latin – audio, I hear; from audire, to hear + generare, to produce.

**Clonic Convulsion**

An involuntary rhythmic alternation between contraction and relaxation of skeletal muscles.

- From Greek – klonos, contraction.

**Convulsion**

An episode, which may be recurrent and episodic, of violent involuntary contractions of a group of muscles of the body, as in a convulsive disorder, or acute, as in a convulsion following a head injury and concussion.

- From Latin – convulsio, cramp + -ion, indicating an action, process, or state.

**Delusional Disorder Due to a General Medical Condition**

A mental disorder characterized by one or more delusions that are prominent , but not bizarre, such as being stalked, poisoned, loved from afar, deceived by a sexual partner, or having a physical abnormality.

**Dissociative Disorders Due to a General Medical Condition**

A category of mental disorders with dissociation as a prominent feature.

**Dostoevsky Syndrome**

See Interictal Syndrome (Pg. 375).
Dysarthria
Imperfect articulation of speech caused by paralysis, weakness, or involuntary movements of the muscles involved in speech production.
■ From Greek – *dys-*, bad or abnormal + *arthron*, articulation + *-ia*, indicating a condition or quality.

Dyskinesia
Involuntary repetitive bodily movements.
■ From Greek – *dys-* bad or abnormal + *kinesis* movement + *-ia* indicating a condition or quality.

Dysstasia
Impairment in ability to stand upright.
■ From Greek – *dys-* bad or abnormal + *stasis*, a standing + *-ia*, indicating a condition or quality.

Interictal Syndrome
A condition sometimes observed in people with temporal lobe epilepsy, characterized by intense productiveness, often in writing or artistic work, between convulsions. Also called Dostoevsky Syndrome.
■ From Latin – *inter*, between + *ictus*, struck; from *icere*, to strike + *-alis*, of or relating to.

Organic Disorders
Disorders involving a physical lesion in an organ or body part. An organic mental disorder is one involving disease, dysfunction, or damage affecting the brain, arising from a primary brain disorder or injury, a disorder in another part of the body with secondary effects in the brain, or the effects of a toxic substance. Included in this category are various forms of dementia, cerebral arteriosclerosis, organic affective disorders, organic anxiety disorder, organic catatonic disorder, organic delusional disorder, organic dissociative disorder, organic hallucinosis, organic mood disorder, organic personality disorder, postencephalitic syndrome, and postconcussional disorder. Also called organic brain syndromes (OBS).
■ From Greek – *organikos*, of or pertaining to an organ; from *organon*, an implement; from *ergein*, to work.

Organic Hallucinosis
A mental disorder of persistent or recurrent hallucinations occurring in clear consciousness, sometimes not recognized by the hallucinator as such, arising as a consequence of an organic disorder.

Postconcussional Disorder
A condition following head trauma causing significant concussion, indicated by fatigue, Dyssomnia, headache, vertigo or dizziness, irritability, anxiety, Depression, or labile affect, changes in personality, and apathy. Also called Postconcussion Syndrome.
■ From Latin – *post*, after + *concussus*, violently shaken, from *concutere*, to shake
violently; from *quatere*, to shake

Postconcussion Syndrome.
See Postconcussional Disorder (Pg. 375).

Postencephalitic Syndrome
An organic mental disorder following recovery from viral or bacterial encephalitis, characterized by non-specific and variable behavioral change, including Paralysis, deafness, Amnesia, Aphasia, Apraxia, or Acalculia.

Psychomotor Epilepsy
See Temporal Lobe Epilepsy (Pg. 376).

Psychomotor Seizure
A seizure of the type found in temporal lobe epilepsy, without any evidence of a convulsion.

Seizure
A sudden attack of a disorder, especially a convulsion.

Shaken Baby Syndrome
A condition characterized by cranial injury, retinal hemorrhage, etc., observed in infants who have been violently jolted.

Temporal Lobe Epilepsy
A form of epilepsy associated with abnormal electrical discharges radiating from the temporal lobe, characterized by temporary impairment or loss of consciousness, sometimes accompanied by automatism, and abnormal or even antisocial or violent behavior, without any apparent convulsions. Such an episode is often preceded by premonitory auras, Derealization, Déjà Vu, Jamais Vu, or Cacosmia. Also called Psychomotor Epilepsy or Temporal Lobe Syndrome.

Temporal Lobe Seizure.
See Psychomotor Seizure

Temporal Lobe Syndrome
See Temporal Lobe Epilepsy.
Mood Disorders

Those with Mood Disorders are individuals with mental disorders who have a disturbance of mood. Unlike affect, which is short in duration, mood is more pervasive with an inappropriate, exaggerated, or limited range of feelings. These moods may consist of extreme highs, extreme lows, or a combination of both over time.

Disorders in this Category

Depressive Disorders

- Depressive Disorder Not Otherwise Specified (Code – 311)
- Dysthymic Disorder (Code – 300.4)
- Late Luteal Phase Dysphoric Disorder (Code – None)
- Luteal Phase Dysphoric Disorder (Code – None)
- Major Depressive Disorder, Recurrent (Code – 296.3x)
- Major Depressive Disorder, Single Episode (Code – 296.2x)
- Premenstrual Dysphoric Disorder (PMDD) (Code – None)
- Premenstrual Syndrome (Code – None)
- Premenstrual Tension (PMT) (Code – None)
- Seasonal Affective Disorder (Code – None)
- Survivor Syndrome (Code – None)
- Williams Syndrome (Code – None)

Bipolar Disorder

- Bipolar I Disorder Not Otherwise Specified (Code – 296.80)
- Bipolar I Disorder, Most Recent Episode Depressed (Code – 296.5x)
- Bipolar I Disorder, Most Recent Episode Hypomanic (Code – 296.40)
- Bipolar I Disorder, Most Recent Episode Manic (Code – 296.4x)
- Bipolar I Disorder, Most Recent Episode Mixed (Code – 296.6x)
- Bipolar I Disorder, Single Manic Episode (Code – 296.0x)
- Bipolar II Disorder (Code – 296.89)
- Cyclothymic Disorder (Code – 301.13)
- Unipolar Depression (Code – None)

Other Mood Disorders

- Mood Disorder Due to a General Medical Condition (Code – 293.83)
- Mood Disorder Not Otherwise Specified (Code – 296.90)
Internet Resources
http://www.psychnet-uk.com/dsm_iv/dysthymic_cyclothymic_episodes.htm
http://www.nurses.info/mental_health_mood_episodes.htm
http://www.a-silver-lining.org/BPNDepth/criteria_e.html
http://www.psych.uic.edu/chat/education/courses/m2psypath/depression%20pathology%20m2/sld017.htm

Movie Suggestions
• ‘night, Mother
• Alice et Martin
• Alone in the T-Shirt Zone
• Anna Karenina
• Bell Jar, The
• Blue Sky
• Call Me Anna
• Captain Newman, M.D.
• Cobb
• Crossover
• Dancing in the Dark
• Death in Small Doses
• Deer Hunter, The
• Ed Wood
• Eraser head
• Evening Star, The
• Fear Strikes Out
• Field, The
• Fox and His Friends
• Friend of the Deceased, A Full Blast
• Girl Interrupted
• Good Morning Vietnam
• Hairdresser’s Husband, The
• Hamlet
• Harold and Maude
• Horse Feathers
• Horse Whisperer, The
• Hours, The
• Hospital, The
• Inside Moves
• It’s a Wonderful Life
• Juliet of the Spirits
• Kadosh
• King of Marvin Gardens
• Last Picture Show, The
• Legend of Bagger Vance, The
• Life Upside Down
• Mad Love
• Manic
• Marine Life
• Mishima
• Modern Times
• Mommie Dearest
• Mosquito Coast, The
• Mr. Jones
• My First Wife
• Natural Enemies
• Network
• Nightmare Alley
• No Looking Back
• Ordinary People
• Outery, The
• Pola X
• Pollack
• Prozac Nation
• Repulsion
• Set Me Free
• Seventh Veil, The
• Shrike, The
• Snake Pit, The
• Solas
• Sophie's Choice
• Spun
• Summer Wishes, Winter Dreams
• Tenant, The
• Through a Glass, Darkly
• Tom and Viv
• Umberto D.
• Unstrung Heroes
• Vincent
• Vincent & Theo
• Water Drops on Burning Rocks
• Woman Under the Influence, A
• Wrong Man, The
**Additional Disorders**

**Late Luteal Phase Dysphoric Disorder**
Another name for [Premenstrual Syndrome](#) with prominent symptoms of mood episodes.

**Luteal Phase Dysphoric Disorder**
See [Premenstrual Syndrome](#) (Pg. 378).

**Premenstrual Syndrome**
A condition in women in which signs and symptoms such as the following tend to appear regularly during the week before and disappear within a few days of the onset of menstruation: depressed mood, anxiety, labile affect, persistent anger and irritability, decreased interest in usual activities, difficulty in concentrating, fatigue, Hypersomnia or Insomnia, and Somatic Symptoms such as breast tenderness, headaches, joint or muscle pain, and a sensation of bloating. Also called late Luteal Phase Dysphoric Disorder, Premenstrual Dysphoric Disorder (PMDD), and Premenstrual Tension (PMT).
- From Latin – *prae* before + *mensuralis* monthly; from *mensis*, a month.

**Premenstrual Tension**
See [Premenstrual Syndrome](#)

**Premenstrual Dysphoric Disorder (PMDD)**
See [Premenstrual Syndrome](#)

**Seasonal Affective Disorder (SAD)**
Some people suffer from symptoms of Depression during the winter months, with symptoms subsiding during the spring and summer months. This may be a sign of Seasonal Affective Disorder (SAD). SAD is a mood disorder associated with Depression episodes and related to seasonal variations of light. SAD was first noted before 1845, but was not officially named until the early 1980’s. As sunlight has affected the seasonal activities of animals (i.e., reproductive cycles and hibernation), SAD may be an effect of this seasonal light variation in humans. As seasons change, there is a shift in our “biological internal clocks” or circadian rhythm, due partly to these changes in sunlight patterns. This can cause our biological clocks to be out of step with our daily schedules. The most difficult months for SAD sufferers are January and February, and younger persons and women are at higher risk. Symptoms Include: regularly occurring symptoms of Depression, including excessive eating and sleeping, and weight gain during the fall or winter months; full remission from Depression in the spring and summer months; symptoms have occurred in the past two years, with no non-seasonal Depression episodes; seasonal episodes substantially outnumber non-seasonal Depression episodes; a craving for sugary and/or starchy foods.

**Seasonal Mood Disorder**
See [Seasonal Affective Disorder](#) (Pg. 379).
Survivor Syndrome
A term introduced by the U.S. psychiatrist Robert Jay Lifton (b. 1926) for a pattern of responses often seen in survivors of terrible ordeals, the most important symptoms being Anhedonia, Chronic Anxiety, Depression, Dyssomnias, and Nightmares.

Williams Syndrome
A rare condition (estimated to occur in 1 out of 20,000 births) characterized by delayed physical and mental development, leading to mild Mental Retardation, coupled with strengths in such areas of functioning as language usage, face recognition, social skills, and musical performance. It was discovered in 1993 that the syndrome is caused by the deletion of the gene that directs the manufacture of elastin, a protein providing strength and elasticity to blood vessels, from one of the two copies of chromosome 7 present in every body cell. People with this syndrome, who are often called Williams people or Williams children, have facial features reminiscent of elves or pixies, hoarse voices, hyperacusis or extreme sensitivity to noise, cardiovascular problems, and elevated levels of calcium in the blood. Named after the New Zealand cardiologist John Cyprian Phipps Williams (born 1922) who first described it in 1961.

Unipolar Depression
A form of Depression that occurs within a mood disorder with symptoms of Depression only, without Manic Episodes.
- From Latin – unus, one + polaris, of or relating to a pole; from polus, a pole.
Other Conditions That May Be a Focus of Clinical Attention

Other Conditions That May Be a Focus of Clinical Attention is a comprehensive list of mental disorders that are not technically mental disorder. However, these disorders may lead or cause an individual to require psychiatric attention.

Disorders in this Category

*Psychological Factors Affecting Medical Condition*

- Psychological Factor Affecting Medical Condition (Code – 316)

*Medication-Induced Movement Disorders*

- Medication-Induced Movement Disorder Not Otherwise Specified (Code – 333.90)
- Neuroleptic Malignant Syndrome (Code – 333.92)
- Neuroleptic-Induced Acute Akathisia (Code – 333.99)
- Neuroleptic-Induced Acute Dystonia (Code – 333.7)
- Neuroleptic-Induced Akinesia (Code – None)
- Neuroleptic-Induced Bradykinesia (Code – None)
- Neuroleptic-Induced Extrapiramidal (Code – None)
- Neuroleptic-Induced Parkinsonism (Code – 332.1)
- Neuroleptic-Induced Postural Tremor (Code – 333.1)
- Neuroleptic-Induced Tardive Dyskinesia (Code – 333.82)

*Relational Problems*

- Partner Relational Problem (Code – V61.20)
- Relational Problem Not Otherwise Specified (Code – 62.8)
- Relational Problem Related to a Mental Disorder or General Medical Condition (Code – V61.9)
- Sibling Relational Problem (Code – V61.10)

*Problems Related to Abuse or Neglect*

- Battered Baby Syndrome (Code – None)
- Battered Child Syndrome (Code – None)
- Battered Wife Syndrome (Code – None)
- Elder Abuse (Code – None)
- Factitious Disorder by Proxy (Code – None)
- Failure to Thrive (FTT) (Code – None)
- Feral Child (Code – None)
- Neglect of Child (Code – V61.21)
- Parental Alienation Syndrome (Code – None)
- Physical Abuse of Adult (Code – None)
- Physical Abuse of Child (Code – V61.21)
• Sexual Abuse (Code – None)
• Sexual Abuse of Adult (Code – None)
• Sexual Abuse of Child (Code – V61.21)
• Spouse Abuse (Code – None)

**Additional Conditions That May Be a Focus of Clinical Attention**

• Academic Problem (Code – V62.3)
• Acculturation Problem (Code – 62.4)
• Adult Antisocial Behavior (Code – 71.01)
• Age-Related Cognitive Decline (Code – 780.9)
• Bereavement (Code – 62.82)
• Borderline Intellectual Functioning (Code – 62.89)
• Compensation Neurosis (Code – None)
• Identity Problem (Code – 313.82)
• Malingering (Code – V65.2)
• Noncompliance With Treatment (Code – V15.81)
• Occupational Problem (Code – 62.2)
• Pathomimicry (Code – None)
• Pathomimicry (Code – None)
• Phase of Life Problem (Code – 62.89)
• Religious or Spiritual Problem (Code – V62.89)

**Internet Resources**
See individual Internet Resources for Internet resources.

**Movie Suggestions**
• 1000 Acres
• Absolutely Positive
• Accidental Tourist
• Accused, The
• Adam
• Afrique mon Afrique
• Alive and Kicking
• All That Jazz
• Always
• Amazing Grace
• An Early Frost
• And the Band Played On
• And Then There Was One
• Andre's Mother
• Angel Heart
• Angels in America
• Angle Baby
• As Is
• As Good as it Gets
• At War with Home
• Ausgerechnet Zoe
• Avalon
• Awakenings
• Baby Boom
• Baby M
• Bad Seed
• Basketball Diaries
• Bastard out of Carolina
• Beaches
• Bed of Roses
• Before I Sleep
• Behind the Red Door
• Bell Jar
• Benny and Joon
• Bienvenido-Welcome
• Big
• Big Chill
• Black and Blue
• Bloodbrothers, The Joey DiPaolo Story
• Blue
• Boost
• Boston Strangler
• Boy with the Green Hair
• Boy Who Could Fly
• Boys Next Door
• Boys on the Side
• Broadcast News
• Buddies
• Burning Bed
• Call Me Anna
• Chantilly Lace
• Chocolate Babies
• Choices of the Heart: The Margaret Sanger Story
• Christmas Carol
• Citizen Ruth
• Citizen Kane
• Citizen Cohen
• Clean and Sober
• Closer
• Closet Land
• Common Threads, Stories from the Quilt
• Corrina, Corrina
• Cries From the Heart
• Crimes of the Heart
• Cry for Help: The Tracey Thurman Story
• Cure, The
• Dad
• Damage
• Damaged
• Darkness Before Dawn
• David's Mother
• Days of Wine and Roses, The
• Dead Poets Society
• Defending Your Life
• Dentas Inferno
• Divided Memories
• Do Fish Do It?
• Do you Know the Muffin Man
• Doctor
• Doctors with Heart
• Dollmaker
• Don't Forget You're Going To Die
• Door to Door
• Dr. Jekyll and Mr. Hyde
• Drop Dead Fred
• Drugstore Cowboy
• Duet for One
• Dying Young
• Early Frost, An
• East of Eden
• Easy Rider
• Eating
• Elephant Man
• Enchantment
• End
• Equus
• Extremities
• Falling Down
• Family of Strangers
• Fan
• Fast Trip, Long Drop
• Fatal Attraction
• Father of the Bride
• Fear Inside
• Field of Dreams
• Flat Liners
• Fly, The
• For the Love of Nancy
• Forrest Gump
• Frances
• Fried Green Tomatoes
• Gathering
• Ghost
• Girls Town
• Go to the Light
• Good Wife
• Grand Canyon
• Great Santini
• Great Imposter
• Gulliver's Travels
• Hand That Rocks the Cradle
• Harvey
• Healers of 400 Parnassus, The
• Hellraiser
• Helter Skelter
• Hot Spell
• House of Cards
• How to Make an American Quilt
• Human Race, The
• Hustler
• I Never Promised You a Rose Garden
• I Know My First Name is Steven
• I Shall Not Be Removed, The Life of Marlon Riggs
• I Never Sang for My Father
• I'll Be Your Mirror
• I'm Losing You
• I'm Dancing as Fast as I Can
• Imaginary Crimes
• Immediate Family
• In and Out
• In the Best Interest of the Child
• In the Shadow of Love, A teen AIDS story
• In the Gloaming
• In una notte di chiaro diluna
• Indian Summer
• Intimate Contact
• Inventing the Abbotts
• It's My Party
• It's a Wonderful Life
• Jack the Bear
• Jeffrey
• Jo Jo Dancer, Your Life is Calling
• Joy Luck Club
• Karen Carpenter Story
• Kate's Story
• Kramer v. Kramer
• Lady Sings the Blues
• Leaving Las Vegas
• Less Than Zero
• Lie
• Life of Jesus, The
• Life and Death on the A List
• Littlest Victims, The
• Living Proof, HIV and the Pursuit of Happiness
• Long Way Home
• Longest Runner
• Longtime Companion
• Looking After Jo Jo
• Looking for Mister Goodbar
• Lorenzo's Oil
• Losing Isaiah
• Lost Weekend
• Love Story
• Love! Valour! Compassion!
• Lust for Life
• M.A.D.D.: Mothers Against Drunk Driving
• Made in Heaven
• Man Who Shot Liberty Valance
• Man that I love, The
• Marvin's Room
• Mary Reilly
• Mask
• Memories of Me
• Memory of Us
• Men Don’t Tell
• Men's Club
• Miracle of Kathy Miller
• Miracle Worker
• Misery
• Mission
• Mommie Dearest
• Moonlight and Valentino
• Morning After
• Mother's Prayer, A
• Mr. Jones
• Mr. Destiny
• Mutter kampft um ihren Sohn, Eine
• My Brother's Keeper
• My Name is W.
• My Life
• My Own Country

• Naked Lunch
• Nell
• Nine and a Half Weeks
• No Easy Way
• No Blame
• Normal Heart, The
• Not My Kid
• Nuts
• On Golden Pond
• Once Upon a Time in the West
• One Flew over the Cuckoo's Nest
• Ordinary People
• Other Side of the Mountain
• Our Sons
• Our Very Own
• Outsiders
• Parenthood
• Parting Glances
• Paul Monette, The Brink of Summer's End
• People vs. Larry Flynt, The Philadelphia
• Place for Annie, A
• Play Misty For Me
• Positive Story
• Postcards from the Edge
• Pretty in Pink
• Prince of Tides, The
• Radio Flyer
• Ragtime
• Rain Man
• Rape and Marriage: The Rideout Case
• Rape of Richard Beck
• Rape of Love
• Rape and Marriage: The Rideout Case
• Regarding Henry
• Rocket Gibraltar
• Roommates
• Rose
• Rush
• Ryan White Story, The
• Safe Passage
• Sarah T: Portrait of a Teenage Alcoholic
• Savage Nights
• Search for Signs of Intelligent Life in the Universe
• She Said No
• Shine
• Sid and Nancy
• Silence of the Lambs
• Simple Twist of Fate
• Six Weeks
• Sleeping with the Enemy
• Sleepless in Seattle
• Sling Blade
• Snake Pit
• Something to Live For, The Alison Gertz Story
• Something About Amelia
• Sophie's Choice
• Soul Food
• St. 'Elmo's Fire
• Stanley and Iris
• Star is Born
• Steel Magnolias
• Stella
• Stranger in the Family
• Stuart Saves His Family
• Summer of '42
• Sweet Nothings
• Sweet Jane
• Sybil
• Taking Back My Life: The Nancy Ziegenmeyer Story
• Tales of Manhattan
• Talking With
• Terms of Endearment
• That's Life
• Thelma and Louise
• This Boy's Life
• Three Faces of Eve
• Time For Witches, A
Additional Disorders

Age-Related Memory Impairment – *Additional Conditions That May Be a Focus of Clinical Attention*

A form of age-related cognitive decline, the predominant symptom of which is a decline in memory occurring naturally as part of the aging process.

Akinesia – *Medication-Induced Movement Disorders*

A decrease in spontaneous motor activity and a reduction in normal gestures, sometimes caused by a lesion in the supplementary motor area.

- From Greek – *a-* (not), *kinesis* (movement) + *-ia*, indicating a condition or quality.

Battered Baby Syndrome – *Problems Related to Abuse or Neglect*

A term coined by the German-born U.S. pediatrician Charles Henry Kempe (born 1922) in an article in the *Journal of the American Medical Association* in 1962 to denote the pattern of physical and psychological injuries inflicted on a baby by intentional neglect or repeated excessive beating by a parent or caretaker.

Battered Wife Syndrome – *Problems Related to Abuse or Neglect*

A non-technical term used loosely to denote the physical and psychological consequences of physical abuse, usually of a woman by her husband or partner, sometimes involving Posttraumatic Stress Disorder.

Battered Child Syndrome – *Problems Related to Abuse or Neglect*

An extension of the term “Battered Baby Syndrome,” used when the victim is an older child.

Bradykinesia – *Medication-Induced Movement Disorders*

Abnormal slowing of bodily movements, notably as a feature of Parkinson's Disease and of Parkinsonism.

- From Greek – *brady* (slow) + *kinesis* (movement) + *-ia*, indicating a condition or quality.

Burnout – *Additional Conditions That May Be a Focus of Clinical Attention*

A work-related condition of emotional exhaustion in which interest in work, personal achievement, and efficiency decline sharply and the sufferer is no longer capable of making decisions. The condition is brought on by the unrelenting stress of pressure at work and is frequently experienced by individuals in jobs involving considerable involvement with people, those who derive a major part of their self-esteem from their work, and those who have few interests outside work.

Compensation Neurosis – *Additional Conditions That May Be a Focus of Clinical Attention*

A collection of symptoms presented by a person who has the prospect of receiving financial compensation for an industrial injury, failed surgical operation, car accident, or the like, susceptible to being interpreted as an attempt to profit from the incident.
Cognitive Derailment – *Additional Conditions That May Be a Focus of Clinical Attention*

A pattern of thinking, closely related to loosening of associations, in which ideas tend to slide from one track on to an unrelated or only indirectly related track. It is manifested in speech by idiosyncratic shifts between meaningful sentences or clauses, rather than within them.

Disorganized Speech – *Additional Conditions That May Be a Focus of Clinical Attention*

In certain mental disorders, notably forms of disorganized schizophrenia, speech suggestive of thought disorder, manifested by cognitive derailment, loosening of associations, incoherence, or replies that are unrelated or only obliquely related to the questions posed.

Elder Abuse – *Problems Related to Abuse or Neglect*

Any form of physical, mental, sexual, or economic exploitation or cruelty by a caretaker towards an elderly person, causing significant harm to the victim.

Extrapyramidal – *Medication-Induced Movement Disorders*

Of or relating to structures outside the pyramidal tract or corticospinal tract of the central nervous system, the pathway responsible for coordinating and integrating motor behavior.

From Latin – *extra*, outside + English – *pyramidal*.

Factitious Disorder by Proxy – *Problems Related to Abuse or Neglect*

A pattern of behavior included in the DSM-IV appendix of conditions meriting further study characterized by international feigning of physical or psychological signs or symptoms in another person who is being cared for, without any economic or other external incentive for the behavior, the motive being to procure medical treatment for the person being cared for and thereby to assume a sick role by proxy. According to the British pediatrician (Samuel) Roy (later Sir Roy) Meadow (born 1933), who was the first to identify the phenomenon and who coined the alternative term Münchausen by Proxy Syndrome (MBPS) in 1977, it is not a psychological disorder, but a form of physical or psychological abuse of children or others being cared for.

Failure to Thrive (FTT) – *Problems Related to Abuse or Neglect*

Failure of an infant to grow satisfactorily compared with the average for that community. It is detected by regular measurements and plotting on centile charts. It can be the first indication of a serious underlying condition, such as kidney or heart disease or malabsorption, or it may result from problems at home, particularly nonaccidental injury.

Feral Child – *Problems Related to Abuse or Neglect*

A Feral Child is one who has lived in isolation from human contact starting from a very young age. These children are unaware of the human behavior of others and are often not exposed to human contact or language. A Feral Child is an extremely rare phenomenon. Around 100 cases over the past few centuries are documented. Feral children may be separated from society by being lost or abandoned in the wild. The category also includes children who have been purposely kept apart from human society or kept in a room in solitary confinement. Sometimes abandonment is due to parents rejecting a child's severe
intellectual impairment or physical disability, and some Feral children experience severe child abuse or trauma before being abandoned. Some Feral children who end up in the wild are reared by wild animals such as wolves or bears and/or may become integrated into animal groups. Despite being normally considered hostile to humans, such animals may in fact adopt abandoned human babies as their own, particularly if they have lost their own young.

Loosening of Associations – Additional Conditions That May Be a Focus of Clinical Attention
A form of thought disorder, closely related to cognitive derailment, characterized by speech that shifts between topics only minimally related to one another, usually without the speaker being aware of the disconnectedness of the stream of ideas.

Mental Impairment – Additional Conditions That May Be a Focus of Clinical Attention
The condition of significant or severe impairment of intellectual and social functioning associated with abnormally aggressive or seriously irresponsible behavior.

Mental Handicap – Additional Conditions That May Be a Focus of Clinical Attention
Intellectual functioning that is below the average, irrespective of cause. It is usually related to congenital conditions, but can arise later in life through brain damage. Assuming a normal intelligence quotient (IQ) of 90 to 110, impairment is often described as borderline (IQ 68–85), mild (IQ 52–67), moderate (IQ 36–51), severe (IQ 20–35), and profound (IQ under 20).

Nonaccidental Injury (NAI) – Problems Related to Abuse or Neglect
Injury inflicted on babies and young children; the perpetrator is usually an adult – often a parent or step-parent. Most commonly seen in babies aged six months or less, it usually takes the form of bruising, particularly on the face; bite marks; burns or scalds, particularly cigarette burns; and bone injuries, especially spiral fractures of the long bones in the limbs and skull fractures. Internal injuries may be fatal. Careful examination often reveals several injuries of different ages, indicating long-term abuse. NAI usually has serious consequences for the child, including failure to thrive and behavioral problems. Known colloquially as the Battered Baby (or Child) Syndrome it may be precipitated by many factors, including relationship difficulties, social problems, and ill health, and is more common if the child is handicapped. It is often found that abusers suffered similar abuse themselves when young. Many abused children suffer further injury if discharged into the same environment with no support. A child at considerable risk may need to be removed from the family home.

Parental Alienation Syndrome – Problems Related to Abuse or Neglect
The systematic denigration by one parent by the other with the intent of alienating the child from the other parent. The purpose of the alienation is usually to gain or retain custody without the involvement of the other parent. The alienation usually extends to the other parent’s family and friends as well.

Pathomimesis – Additional Conditions That May Be a Focus of Clinical Attention
Mimicry of a disease or disorder, particularly Malingering (Pg. 205).
Pathomimicry – *Additional Conditions That May Be a Focus of Clinical Attention*
Mimicry of a disease or disorder, particularly Malingering (Pg. 205).

Sexual Abuse – *Problems Related to Abuse or Neglect*
The subjection of a child or other vulnerable person to sexual activity liable to cause physical or psychological damage.

Spouse Abuse – *Problems Related to Abuse or Neglect*
Any form of physical or mental exploitation or cruelty towards a husband, wife, or partner, causing significant harm to the victim.
Personality Disorders

Those who have Personality Disorders are individuals with mental disorders related to personality problems that are enduring in nature and which play a predominant role in an individual’s life; the disorder is constant. This disorder consists of problems with affects, thoughts, emotions, interpersonal functioning, and impulse control.

Disorders in this Category
- Affective Personality Disorder (Code – None)
- Amoral Personality Disorder (Code – None)
- Anankastic Personality Disorder (Code – None)
- Antisocial Personality Disorder (Code – 301.7)
- Asocial Personality Disorder (Code – None)
- Asthenic Personality Disorder (Code – None)
- Avoidant Personality Disorder (Code – 301.82)
- Borderline Personality Disorder (Code – 301.83)
- Compensatory Narcissistic Personality Disorder (Code – None)
- Compulsive Hoarding (Code – None)
- Cyclothymic Personality Disorder (Code – None)
- Dependent Personality Disorder (Code – 301.6)
- Dissocial Personality Disorder (Code – None)
- Emotionally Unstable Personality Disorder (Code – None)
- Explosive Personality Disorder (Code – None)
- Histrionic Personality Disorder (Code – 301.50)
- Hysterical Personality Disorder (Code – None)
- Inadequate Personality Disorder (Code – None)
- Masochistic Self-Defeating Personality Disorder (Code – None)
- Multiple Personality Disorder (Code – None)
- Narcissistic Personality Disorder (Code – 301.81)
- Negativistic Personality Disorder (Code – None)
- Obsessive-Compulsive Personality Disorder (Code – 301.4)
- Paranoid Personality Disorder (Code – 301.0)
- Passive-Aggressive Personality Disorder (Code – 301.9)
- Personality Disorder Not Otherwise Specified (Code – None)
- Psychopathy (Code – None)
- Sadistic Personality Disorder (Code – None)
- Schizoid Personality Disorder (Code – 301.20)
- Schizotypal Personality Disorder (Code – 301.22)
- Self-Defeating Personality Disorder (Code – None)
Internet Resources
http://www.focusas.com/PersonalityDisorders.html
http://www.4degreez.com/misc/personality_disorder_test.mv
http://mentalhelp.net/poc/center_index.php?id=8
http://pdf.uchc.edu/
http://www.nmha.org/infoctr/factsheets/91.cfm

Movie Suggestions
- 2001: A Space Odyssey
- A Place In The Sun
- A Few Good Men
- A Shock To the System
- A Danger of Love
- Accidental Tourist, The
- Accused, The
- After Hours
- Albino Alligator
- Alfie
- Alias Nick Beal
- Alien
- All that Jazz
- All About Eve
- Along Came a Spider
- American Psycho
- An American Werewolf In London
- Anatomy Of A Murder
- And Then There Were None
- Angel Heart
- Angel On My Shoulder
- Antonia’s Line
- Anywhere but Here
- Apartment Zero
- Apocalypse Now
- Aquirre, The Wrath of God
- Arsenic and Old Lace
- Assassination Bureau, The
- Bad Lieutenant, The
- Bad Seed
- Badlands
- Basic Instinct
- Betty Blue
- Black Widow
- Blade Runner
- Blue Velvet
- Body Heat
- Bonnie and Clyde
- Boogie Nights
- Boston Strangler, The
- Bound
- Boxing Helena
- Boy Who Cried Bitch, The
- Boys From Brazil, The
- Boyz N the Hood
- Breathless
- Bridge on the River Kwai, The
- Bullets over Broadway
- Butley
- Cabinet of Dr. Caligari, The
- Caine Mutiny, The
- California Split
- Cape Fear
- Casablanca
- Casualties of War
- China Lake Murders, The
- Citizen Kane
- Clay Pigeons
- Clockwork Orange, A
- Cobra
- Compulsion
- Con Air
- Confessions of a Serial Killer
- Conversation, The
- Copycat
- Crimes and Misdemeanors
- Criminal Law
- Cruising
- Damm Yankees
- Day Of The Jackal, The
- Dead Man Walking
- Deliberate Stranger, The
- Deliverance
- Dementia 13
- Devil and Daniel Webster, The
- Devil's Advocate
- Dial "M" For Murder
- Die Hard
- Disclosure
- Dog Day Afternoon
- Double Indemnity
- Down and Dirty
- Dr. Jekyll and Mr. Hyde
- Dream Lover
- Dressed to Kill
- Duel in the Sun
- Executioner's Song, The
- Exorcist, The
- Experiment in Terror
- Extremities
- Eye of the Needle
- Face Off
- Fallen
- Falling Down
- Fantasia
- Fargo
- Fatal Attraction
- Ferrius Bullers Day Off
- Fight Club
- Final Cut, The
- Five Corners
- Five Easy Pieces
• Forbidden Planet
• Frances
• Freaks
• Frenzy
• From the Life of the Marionettes
• Gambler, The
• Girl Interrupted
• Godfather, The
• Godfather II, The
• Godfather III, The
• Goldfinger
• Gone with the Wind
• Goodfellas
• Grifters, The
• Gypsy
• Hand That Rocks the Cradle, The
• Hannibal
• Heavenly Creatures
• Henry: Portrait of a Serial Killer
• High Sierra
• Honeymoon Killers, The
• House of Games
• House of Cards
• Hud
• I Spit on Your Grave
• I Confess
• In the Company of Men
• In the Line of Fire
• In Cold Blood
• It's A Mad Mad Mad Mad World
• Jagged Edge, The
• Jaws
• Jerry Maguire
• Judgment At Nuremberg
• Just Cause
• California
• Killing Fields, The
• Kiss of Death
• Knife in the Water
• La Cage aux Folles

• La Femme Nikita
• La Femme Nikita
• Last of Sheila, The
• Last Rites
• Last Seduction, The
• Last Supper, The
• Last Tango in Paris
• Lawrence of Arabia
• Le Boucher
• Leave Her to Heaven
• Leopold and Loeb
• Lethal Weapon
• Lilith
• List of Adrian Messenger, The
• Lodger, The
• Long Day's Journey into Night
• Look Who's Talking
• Looking for Mr. Goodbar
• M
• M*A*S*H
• Man Bites Dog
• Manchurian Candidate, The
• Manhunter
• Marine
• Marriage of Maria Braun, The
• Midnight Express
• Mildred Pierce
• Minus Man
• Misery
• Monsieur Verdoux
• Monster
• Murder in the First
• Murder By Decree
• Murderous Affair
• Natural Born Killers
• New Janitor, The
• Night Must Fall
• Night of the Hunter
• Night Porter, The
• Nightmare On Elm Street

• Nine ½ Weeks
• No Way Out
• No Way To Treat A Lady
• Nuts
• Obsessed
• Odd Couple, The
• Odd Couple, The
• Omen, The
• Once Were Warriors
• Once Upon A Time in the West
• Once Upon A Time In America
• One Flew Over The Cuckoo's Nest
• Out of the Darkness
• Out of the Past
• Pacific Heights
• Package, The
• Paper Moon
• Patton
• Peeping Tom
• Platoon
• Play Misty for Me
• Point of No Return
• Poltergeist
• Postman Always Rings Twice, The
• Pretty Maids All In A Row
• Prick Up Your Ears
• Primal Fear
• Psycho
• Public Enemy #1
• Pulp Fiction
• Pumpkin Eater, The
• Raging Bull
• Raiders Of the Lost Ark
• Raising Cain
• Rampage
• Rashomon
• Remains of the Day
• Reminiscences of a Plain Girl
• Reservoir Dogs
• Ripper, The
• River's Edge
• Romeo Is Bleeding
• Rope
• Rosemary's Baby
• Royal Tananbaums, The
• Santa Sangre
• Saving Private Ryan
• Scarface
• Schindler's List
• Scream
• Sea of Love
• Sea Wolf, The
• Seance on a Wet Afternoon
• Secretary, The
• Serial Mom
• Serial Killers
• Servant, The
• Seven Beauties
• Seven
• Sex, Lies, and Videotapes
• Shadow of a Doubt
• Shallow Grave
• Shampoo
• Shane
• Silence of the Lambs, The
• Singin' in The Rain
• Single White Female
• Sleeping with the Enemy
• Something Wild
• Sophie's Choice
• Sound of Music, The
• Speed
• Stagecoach
• Star Trek
• Stardust Memories
• Stone Boy, The
• Story of Vivien Leigh & Olivier
• Strangers on a Train
• Straw Dogs
• Streetcar Named Desire, A
• Sunset Boulevard
• Switchback
• Swoon
• Sybil
• Tattoo
• Taxi
• Taxi Driver
• Taxi Driver
• Ten Rillington Place
• Terminator, The
• Terminator 2: Judgment Day
• Texas Chain Saw Massacre, The
• The English Patient
• The Hand That Rocks the Cradle
• Thelma and Louise
• Thing
• Third Man, The
• Thirty-Nine Steps, The
• Tightrope
• Time to Kill, A
• Time After Time
• Timecop
• Titanic
• To Play the King
• To Die For
• To Kill A Mockingbird
• Toto le Heros
• Treasure of Sierra Madre, The
• Triumph of the Spirit
• Twelve Monkeys
• Two Women
• Usual Suspects, The
• Vertigo
• Virgin Spring, The
• Wall Street
• War of the Roses
• What about Bob?
• White Heat
• Witches of Eastwick, The
• Witness For The Prosecution
• Wolf Man, The
• Wolf
• Wrong Man, The
• Wuthering Heights
• Young Poisoner's Handbook, The
• Zelig
**Additional Disorders**

**Affective Personality Disorder**
Personality disorder characterized by lifelong predominance of a pronounced mood which may be persistently depressive, persistently elated, or alternately one then the other. During periods of elation there is unshakeable optimism and an enhanced zest for life and activity, whereas periods of Depression are marked by worry, pessimism, low energy output, and a sense of futility.

**Amoral Personality Disorder**
See *Antisocial Personality Disorder*

**Anankastic Personality Disorder**
Personality disorder characterized by feelings of personal insecurity, doubt and incompleteness leading to excessive conscientiousness, checking, stubbornness, and caution. There may be insistent and unwelcome thoughts or impulses which do not attain the severity of an obsessional neurosis. There is perfectionism and meticulous accuracy and a need to check repeatedly in an attempt to ensure this. Rigidity and excessive doubt may be conspicuous.

**Anxious Personality Disorder**
See *Avoidant Personality Disorder*

**Asocial Personality Disorder**
See *Antisocial Personality Disorder*

**Asthenic Personality Disorder**
Personality disorder characterized by passive compliance with the wishes of elders and others and a weak inadequate response to the demands of daily life. Lack of vigor may show itself in the intellectual or emotional spheres; there is little capacity for enjoyment.

**Avoidant Personality Disorder**
A personality disorder characterized by a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to criticism, disapproval, or rejection, beginning by early adulthood and indicated by such signs and symptoms as avoidance of work involving significant interpersonal contact; unwillingness to associate with people unless certain of being liked; restraint in intimate relationships for fear of being shamed or ridiculed; preoccupation with criticism or rejection; inhibition in new social situations arising from feelings of inadequacy; self-image as inept, unappealing, and inferior to others; and reluctance to engage in activities carrying the risk of embarrassment. Also called Compensatory Narcissistic Personality Disorder

**Compensatory Narcissistic Personality Disorder**
See *Avoidant Personality Disorder*

**Compulsive Hoarding**
Compulsive Hoarding is a complex psychological disorder that can significantly disrupt a person's life. Hoarding occurs when a person acquires and saves possessions that have either little or no value or have some perceived value, and then has great difficulty in discarding their possessions. This usually results in clutter. Hoarding behavior can often lead to other problems. Often associated with Obsessive-Compulsive Disorder or Obsessive-Compulsive Personality Disorder and Depression, hoarding can affect people's lives across all levels of functioning. It is common for hoarders to have interpersonal difficulties, family tension, poor self-esteem, poor social skills, weak decision-making skills, occupational issues, and even legal issues. In addition, there are physical risks, such as falls and fires within the home environment.

Cyclothymic Personality Disorder
A pervasive pattern of pronounced periodic changes in mood, behavior, thinking, sleep, and energy levels, beginning by early adulthood and present in a variety of contexts, as indicated by seven or more of the following: 1) depressive periods; 2) excessive involvement in pleasurable activities with lack of concern for the high potential of painful consequences alternating with restriction of involvement in pleasurable activities and guilt over past activities; 3) alternates between over-optimism or exaggeration of past achievement and a pessimistic attitude toward the future, or brooding about past events; 4) more talkative than usual, with inappropriate laughing, joking, and punning, and then less talkative, with tearfulness or crying; 5) decreased need for sleep alternating with hypersomnia; 6) shaky self-esteem; 7) periods of sharpened and creative thinking alternating with periods of mental confusion and apathy; 8) marked unevenness in the quantity and quality of productivity, often associated with unusual working hours; 9) engages in uninhibited people-seeking that may lead to hypersexuality alternating with introverted self-absorption; 10) frequently shifts line of work, study, interest, or future plans; 11) engages in occasional financial extravagance; 12) tendency toward promiscuity, with repeated conjugal or romantic failure; 13) may use alcohol or drugs to control moods or to augment excitement; 14) irritable-angry-explosive outbursts that alienate loved ones; 15) makes frequent changes in residence or geographical location.

Dissocial Personality Disorder
Another name for Antisocial Personality Disorder. The diagnostic criteria are similar, with the addition of incapacity to maintain enduring relationships, though with no difficulty in establishing them, and incapacity to experience guilt or to profit from adverse experience, particularly punishment.

Emotionally Unstable Personality Disorder
Personality disorder characterized by a definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious. There is a liability to outbursts of emotion and incapacity to control the behavioral explosions. There is a tendency to quarrelsome behavior and to conflicts with others, especially when impulsive acts are thwarted or censored. Two types may be distinguished: the impulsive type, characterized predominantly by emotional instability and lack of impulse control; and the borderline type, characterized in addition by disturbances in self-image, aims, and internal preferences, by chronic feelings of emptiness, by intense and unstable
interpersonal relationships, and by a tendency to self-destructive behavior, including suicide gestures and attempts.

Explosive Personality Disorder
See Intermittent Explosive Disorder.

Hysterical Personality Disorder
Personality disorder characterized by shallow, labile affectivity, dependence on others, craving for appreciation and attention, suggestibility and theatricality. There is often sexual immaturity, e.g., frigidity and over-responsiveness to stimuli. Under stress, hysterical symptoms (neurosis) may develop.

Inadequate Personality Disorder
A term occasionally used for a condition, without evidence of any mental disorder, characterized by lack of judgement, ambition, and initiative, leading to failure at almost everything attempted.

Masochistic Personality
See Masochistic Self-Defeating Personality Disorder

Masochistic Self-Defeating Personality Disorder
A pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The person may often avoid or undermine pleasurable experiences, be drawn to situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least five of the following: 1) chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available; 2) rejects or renders ineffective the attempts of others to help him of her; 3) following positive personal events (e.g., new achievement), responds with Depression, guilt, or a behavior that produces pain; 4) incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated, makes fun of spouse in public, provoking an angry retort, then feels devastated; 5) rejects opportunities for pleasure, or is reluctant to acknowledge enjoying himself or herself despite having adequate social skills and the capacity for pleasure; 6) fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so, e.g., helps fellow students write papers, but is unable to write his or her own; 7) uninterested in or rejects people who consistently treat him or her well, e.g., is unattached to caring sexual partners; 8) engages in excessive self-sacrifice that is unsolicited by the intended recipients of the sacrifice. The behaviors do not occur exclusively in response to, or in anticipation of, being physically, sexually, or psychologically abused. The behaviors do not occur only when the person is depressed.

Multiple Personality Disorder
A psychiatric disorder in which the affected person has two or more distinct, and often contrasting, personalities. Dissociative Identity Disorder is the current name for Multiple Personality Disorder. As each personality assumes dominance, it determines attitudes and
behavior and usually appears to be unaware of the other personality (or personalities). The condition is thought to be a late result of child abuse.

**Negativistic Personality Disorder**
See Passive-Aggressive Personality Disorder

**Passive-Aggressive Personality Disorder**
A personality disorder (not included in the DSM-IV classification) characterized by a pervasive pattern of negativism, with passive resistance, complaints of being misunderstood, sullenness and argumentativeness, unreasonable scorn for authority, envy and resentment, alternation between hostile defiance and contrition, and general discontentment. People with the disorder tend to obtain high scores on measures of assertiveness and low scores on measures of warmth. Also called Negativistic Personality Disorder.

**Personality Disorder with Predominantly Sociopathic or Asocial Manifestation**
Personality disorder characterized by disregard for social obligations, lack of feeling for others, and impetuous violence or callous unconcern. There is a gross disparity between behavior and the prevailing social norms. Behavior is not readily modifiable by experience, including punishment. People with this personality are often affectively cold and may be abnormally aggressive or irresponsible. Their tolerance to frustration is low; they blame others or offer plausible rationalizations for the behavior which brings them into conflict with society.

**Psychopathy**
A mental disorder roughly equivalent to Antisocial Personality Disorder, but with emphasis on affective and interpersonal traits such as superficial charm, pathological lying, egocentricity, lack of remorse, and callousness that have traditionally been regarded by clinicians as characteristic of psychopaths, rather than social deviance traits such as need for stimulation, parasitic lifestyle, poor behavioral controls, impulsivity, and irresponsibility that are prototypical of Antisocial Personality Disorder. Whether psychopathy and Antisocial Personality Disorder share a common referent is an open question.
- From Greek – psyche, mind + pathos, suffering.

**Sadistic Personality Disorder**
A pervasive pattern of cruel, demeaning, and aggressive behavior, beginning by early adulthood, as indicated by the repeated occurrence of at least four of the following: 1) used physical cruelty or violence for the purpose of establishing dominance in a relationship, not merely to achieve some noninterpersonal goal, such as striking someone in order to rob him or her; 2) humiliates or demeans people in the presence of others; 3) treated or disciplined someone under his or her control unusually harshly, e.g., a child, student, prisoner, or patient; 4) amused by, or takes pleasure in, the psychological or physical suffering of others, including animals; 5) lied for the purpose of harming or inflicting pain on others not merely to achieve some other goal; 6) gets other people to do what he or she wants by frightening them through intimidation or even terror; 7) restricts
the autonomy of people with whom he or she has a close relationship, e.g., will not let spouse leave the house unaccompanied or permit teen-age daughter to attend social functions; 8) fascinated by violence, weapons, martial arts, injury, or torture. The behavior has not been directed toward only one person (e.g., spouse, one child) and has not been solely for the purpose of sexual arousal.

Self-Defeating Personality Disorder
A controversial personality disorder is characterized by habitual or recurrent behavior that leads to failure and invites rejection. Also (misleadingly, since no sexual arousal is implied) called Masochistic Personality.

Sociopathy
Also known as Psychopathy. Sociopathy is a personality syndrome often (and usually inaccurately) portrayed in the media: this portrayal has led to certain general misunderstanding about the syndrome. Sociopaths are characterized by certain personality characteristics, including personal charm, selfishness, and impulsiveness, lack of guilt or anxiety, and cruelty. The sociopath usually has some history of minor misbehavior in childhood, which often becomes "deviant" during adolescence. A significant proportion of sociopaths become criminals in adulthood. They may be distinguished from most convicted or known criminals in so far as they are usually “lone wolves,” contrasting with other criminals who tend to belong to gangs which possess their own rules of conduct. The syndrome may have organic pathology; a significant number of sociopaths exhibit unusual EEG patterns.
Schizophrenia and Other Psychotic Disorders

General Characteristics
Schizophrenia and Other Psychotic Disorders consist of individuals with mental disorders who have symptoms of psychosis, delusions or hallucinations. In most disorders of neurosis the individual may know they are not functioning correctly. With Schizophrenia the individual does not know there is a problem; it is in the brain as an internal process verses the external process in the neurosis.

Disorders in this Category
- Brief Psychotic Disorder (Code – 298.8)
- Capgras Syndrome (Code – None)
- Clérambault's Syndrome (Code – None)
- Cotard's Syndrome (Code – None)
- Délire de Dégation (Code – None)
- Delusional Disorder (Code – 297.1)
- Delusional Parasitosis (Code – None)
- Delusions of Parasitosis (Code – None)
- Ekbom's Syndrome II (Code – None)
- Erotomanic Delusional Disorder (Code – None)
- Folie a Deux (Code – None)
- Frégoli Syndrome (Code – None)
- Illusion of Doubles (Code – None)
- Induced Delusional Disorder (Code – None)
- Insanity of Negation (Code – None)
- Intermetamorphosis (Code – None)
- L’illusion De Sosies (Code – None)
- Othello Syndrome (Code – None)
- Psychotic Disorder Due to a General Medical Condition (Code – None)
- Psychotic Disorder Not Otherwise specified (Code – None)
- Schizoaffective Disorder (Code – 295.70)
- Schizophrenia (Code – None)
- Schizophreniform Disorder (Code – 295.40)
- Shared Madness (Code – None)
- Shared Paranoid Disorder (Code – None)
- Shared Psychotic Disorder (Code – 297.3)

Internet Resources
http://www.mentalhealth.com/dis/p20-ps01.html
http://www.nimh.nih.gov/healthinformation/schizophreniamenu.cfm
http://www.schizophreniadigest.com/
http://www.mentalwellness.com/
http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=7416
Movie Suggestions

- Alone in the Dark
- Amadeus
- Angel Baby
- Angel in Red
- Angel at My Table, An
- Beautiful Mind, A
- Bennie & Joon
- Berlin Alexanderplatz
- Betrayed
- Bill of Divorcement, A
- Birdy
- Caine Mutiny, The
- Camille Claudel
- Caveman's Valentine, The
- Clean, Shaven
- Conspiracy Theory
- Couch Trip, The
- Cupid
- David and Lisa
- Dead of Night
- Delusions of Grandeur
- Don Juan DeMarco
- Don't Say a Word
- Dressed to kill
- Entertainer, The
- Fan, The
- Fisher King, The
- Girl Interrupted
- Harvey
- House of Yes
- Housekeeping
- I Never Promised You a Rose Garden
- Images
- K-Pax
- La Dolce Vita
- Lilith
- Lunatics: A Love Story
- Lust for Life
- Mad Love
- Madness of King George, The
- Magic
- Messanger, The: The Story of Joan of Arc
- Misery
- Network
- Outrageous!
- Pi
- Play Misty for Me
- Possessed
- Promise
- Repulsion
- Ruling Class, The
- Saint of Fort Washington, The
- Santa Sangre
- Scissors
- Shine
- Shock Corridor
- Snake Pit, The
- Sophie’s Choice
- Stanley and the Women
- Story of Adele H. The
- Strange Voices
- Stroszek
- Summer of Sam
- Sunset Blvd.
- Sweetie
- Taxi Driver
- Tenant, The
- They Might be Giants
- Through A Glass Darkly
- Twelve Monkeys
- Vanilla Sky
- Wednesday's Child
- Who's Afraid of Virginia Woolf
**Additional Disorders**

**Capgras Syndrome**
A delusional misidentification of familiar people, usually relatives or friends, who are believed to have been replaced by exact doubles or impostors; thus a delusion of under-identification, in contrast to Frégoli Syndrome, which involves over-identification.

**Clérambault's**
A name sometimes applied to Erotomaniac Delusional Disorder, especially in women. Named after the French psychiatrist Gaétan G. de Clérambault (1872–1934), who studied the behavior.

**Cotard's Syndrome**
A pessimistic and distrustful delusional condition characterized by a tendency to deny everything, even to the point of believing that one's body has disintegrated and that one's family no longer exists. Named after the French neurologist Jules Cotard (1840–87), who first described it in 1880.

**Délire de Dégation**
See Cotard's Syndrome

**Delusional Parasitosis**
See Ekbom's Syndrome II

**Delusions of Parasitosis**
See Ekbom's Syndrome II

**Ekbom's Syndrome II**
Chronic tactile hallucinosis; delusional ectoparasitosis, delusions of parasitosis, delusions of skin infestation, formication, monosymptomatic hypochondriasis. Associated persons: Karl Axel Ekbom Description: A delusional syndrome that often presents in patients with significant cognitive abnormalities, usually in middle-aged and elderly female schizophrenics. The patient imagines the symptoms of parasitic infestation of the skin, most often of the outer rectal area. They feel like bugs, worms, or mites are biting, crawling, or burrowing into, under, or out of the skin.

**Erotomanic Delusional Disorder –Psychotic Disorders**
A type of Delusional Disorder in which the central delusion is erotomania, also called Clérambault's Syndrome.

**Folie a Deux**
Also known as Induced Delusional Disorder, Shared Paranoid Disorder, Shared Madness. Delusion or mental illness shared by two people in close association. Another name for Shared Psychotic Disorder, Folie à Trois is a shared delusion shared by three people living together; Folie à Quatre a delusion shared by four people living together, etc.
Frégoli Syndrome
A delusional misidentification of strangers as familiar people in disguise; thus a delusion of over-identification, in contrast to Capgras syndrome, which involves under-identification. Named after Leopoldo Frégoli (1867–1936), an Italian actor of the belle époque who was famous for his ability as a mimic.

L'illusion De Sosies
See Capgras Syndrome.

Illusion of Doubles
See Capgras Syndrome.

Intermetamorphosis
A delusional misidentification in which a familiar person appears to change into someone else.

Induced Delusional Disorder
See Shared Paranoid Disorder

Induced Delusional Disorders
A mental disorder in which a person develops a delusion that is similar in content to that of a closely associated person with a pre-established delusion. Also called Folie à Deux and Shared Paranoid Disorder.

Insanity of Negation
See Cotard's Syndrome

Othello Syndrome
Morbid and irrational jealousy or, if sufficiently severe, jealous delusional disorder. Named after Shakespeare's play Othello and the eponymous character whose sexual jealousy leads him to murder his innocent wife.

Shared Madness
See Shared Psychotic Disorder

Shared Paranoid Disorder
A mental disorder in which a person develops a delusion that is similar in content to that of a closely associated person with a pre-established delusion.
Sexual and Gender Identity Disorders

Those with Sexual and Gender Identity Disorders are individuals with mental disorders related to sexual functioning. The dysfunction consists of a wide range of problems and issues ranging from low sexual desire and sexual arousal to orgasmic problems, pain, and abnormal sexual interests. Additionally, this category contains problems of sexual identity with feelings and beliefs of being the wrong gender; male’s desire to be female and female’s desire to be male.

Disorders in this Category

Sexual Desire Disorders
- Hypoactive Sexual Desire Disorder (Code – 302.71)
- Sexual Aversion Disorder (Code – 302.79)

Sexual Desire Disorders
- Male Erectile Disorder (Code – 302.72)
- Priapism (Code – None)

Orgasmic Disorders
- Female Orgasmic Disorder (Code – 302.73)
- Male Orgasmic Disorder (Code – 302.74)
- Premature Ejaculation (Code – 302.7)

Sexual Pain Disorders
- Dyspareunia (Code – 302.76)
- Sexual Dysfunction Due to a General Medical Condition (Code – None)
- Sexual Dysfunction Not Otherwise Specified (Code – None)
- Vaginismus (Code – 302.51)

Paraphilias
- Acrotomorphilia (Code – None)
- Actual Neurosis (Code – None)
- Airwalker’s (Code – None)
- Apotemnophilia (Code – None)
- Autoerotic Asphyxiation (Code – None)
- Auto-Erotic Asphyxiation (Code – None)
- Bestiality (Code – None)
- Breath Games (Code – None)
- Breath Play (Code – None)
- Choke Chicks (Code – None)
- Coprophilia (Code – None)
- Delilah Syndrome (Code – None)
- Down Low (Code – None)
- Dual-Role Transvestism Fetishistic (Code – None)
- Ecouteur (Code – None)
- Erotic Asphyxiation (Code – None)
- Exhibitionism (Code – 302.4)
- Fetishism (Code – 302.81)
- Friends with Benefits (Code – None)
- Frotteurism (Code – 302.89)
- Gaspers (Code – None)
- Gender Identity Disorder (Code – None)
- Gender Identity Disorder Not Otherwise Specified (Code – 302.6)
- Golden Showers (Code – None)
- Hypoxyphilia (Code – None)
- Katasexualism (Code – None)
- Kleptolagnia (Code – None)
- Klüver–Bucy Syndrome (Code – None)
- Klysmaphilia (Code – None)
- Monopede Mania (Code – None)
- Monopedophilia (Code – None)
- Mysophilia (Code – None)
- Necrophilia (Code – None)
- Nymphomania (Code – None)
- Osphresiolagnia (Code – None)
- Paraphilia Not Otherwise Specified (Code – 309.9)
- Pedophilia (Code – 302.2)
- Peeping Tom (Code – None)
- Scarfing (Code – None)
- Scatting (Code – None)
- Scopophilia (Code – None)
- Scoptophilia (Code – None)
- Scoptophilia (Code – None)
- Sexual Disorder Not Otherwise Specified (Code – 302.9)
- Sexual Masochism (Code – 302.83)
- Sexual Sadism (Code – 302.84)
- Telephone Scatalogia (Code – None)
- Transvestic Fetishism (Code – 302.3)
- Transvestism (Code – None)
- Undinism (Code – None)
- Unipedophilia (Code – None)
- Upskirting (Code – None)
- Uurolagnia (Code – None)
- Voyeurism (Code – 302.82)
- Zooerasty (Code – None)
Internet Resources
http://www.emedicine.com/med/topic3439.htm
http://www.nurses.info/mental_health_sexual_gender.htm
http://www.psychiatry.ufl.edu/addiction/undergraded/course%20material/4.6.pdf
http://www.psychoconsult.co.uk/doctorssite/diseaseareasdoctors/other%20disorders/gendersexual.htm

Movie Suggestions:
• Adjuster, The
• Adventures of Priscilla, Queen of the Desert
• Angels & Insects
• Angels and Insects
• Another Time, Another Place
• Bad Timing: A Sensual Obsession
• Beginner’s Luck
• Belle de Jour
• Birdcage, The
• Blame It on Rio
• Blue Angel, The
• Boston Strangler, The
• Boys Don’t Cry
• Breaking the Waves
• Butcher Boy
• Cabaret
• Caesar and Rosalie
• Caligula
• Carnal Knowledge
• Case of Becky, The
• Cat on a Hot Tin Roof
• Chinatown
• Claire’s Knee
• Close My Eyes
• Collector, The
• Color of Night
• Crash
• Cruising
• Crying Game, The
• Damage
• Dance of Fire
• Danish Girl, The
• Day in the Country, A
• Dead Again
• Different for Girls
• Dr. Jekyll and Mr. Hyde
• Ed Wood
• Equus
• Eve's Bayou
• Exit to Edan
• Fellini Satyricon
• Female Perversions
• Fetishes
• Fists in His Pocket
• Fried Green Tomatoes
• God’s Little Acre
• Good Mother, The
• Happiness
• Harold and Maude
• Henry & June
• House of Yes
• Ju Dou
• Jules and Jim
• Kiss of the Spider Woman
• La Cage aux Folles
• Last Tango in Paris
• Last Exit to Brooklyn
• Lianna
• Lizzie
• Lolita
• Luna
• Manhattan
• Mark The
• Matador
• Me, Myself & Irene
• Menage
• Midnight Cowboy
• Mirage
• Mona Lisa
• Montenegro
• Mrs. Doubtfire
• Murmur of the Heart
• My Beautiful Laundrette
• My Favorite Season
• My Life to Live
• My Own Private Idaho
• My Favorite Season
• Mystery of Alexina, The
• Nos Amours, A
• Nurse Betty
• Of Human Bondage
• Oscar Wilde
• Peeping Tom
• Personal Best
• Pretty Baby
• Pulp Fiction
• Raising Cain
• Rapture
• Rita, Sue and Bob Too
• Rocky Horror Picture Show, The
• Salo, or the 120 of Sodom
• Secretary
• Sergeant, The
• Sex, Lies and Videotape
• Shadow Hours
• Short Cuts
• Sliver
• Some Like It Hot
• Something About Amelia
• Spanking the Monkey
• Spellbound
• Strange One, The
• Suddenly, Last Summer
• Swept Away
• Sybil
• Te Me Up! Tie Me Down
• That Obscure Object of Desire
• This World, Then the Fireworks
• Thousand Acres
• Three Faces of Eve, The
• Three Lives of Karen, The
• Tommy
• Tootsie
• Torch Song Trilogy
• Tran-Sister Radio
• Two Women
• Two-Soul Woman, The
• Unbearable Lightness of Being
• Victor/Victoria
• Virginiana
• Visiting Desire
• Wild Orchid
• Wild Orchid 2: Two Shades of Blue
• World According to Garp, The
• Yental
Additional Disorders

Acrotomorphilia – *Paraphilia*
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior associated with having a partner with an amputated leg. It is found among both heterosexual and homosexual men and women and should be carefully distinguished from Apotemnophilia. People with Acrotomorphilia often refer to themselves as “devotees.” Also called Monoped Mania, Monopedophilia, or Unopedophilia, but the latter two forms are liable to cause confusion with Pedophilia.

- From Greek – *akron*, a tip + *tome*, a cut + *morphē*, a form or shape + *philos*, loving; from *phileēin*, to love + -*ia*, indicating a condition or quality.

Actual Neurosis – *Paraphilia*
In psychoanalysis, a form of neurosis that does not have its origin in infantile conflicts, but in the present, the symptoms resulting directly from the absence or inadequacy of sexual satisfaction and not appearing as symbolic forms of expression. Sigmund Freud (1856–1939), who introduced the concept in 1898 in the article “Sexuality in the Aetiology of the Neuroses” originally identified as anxiety neurosis (Generalized Anxiety Disorder and neurasthenia as the actual neuroses, and he later added hypochondria).

- From German – *aktual*, present-day.

Airwalkers – *Paraphilia*
See *Autoerotic Asphyxiation*

Apotemnophilia – *Paraphilia*
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior associated with having one of one's own limbs (usually a leg) amputated. It should be carefully distinguished from Acrotomorphilia.

- From Greek *apo*, away + *temnein*, to cut + *philos*, loving, from *phileēin*, to love + -*ia*, indicating a condition or quality.

Auto-Erotic Asphyxiation – *Paraphilia*
See *Autoerotic Asphyxiation*

Autoerotic Asphyxiation – *Paraphilia*
The process of cutting off one's air supply to increase the intensity of orgasm during self-pleasure. Autoerotic Asphyxiation, is also known as Breath Control Play, Erotic Asphyxiation, Auto-Erotic Asphyxiation (if solo), Breath Games, Breath Play, Hypoxyphilia, Scarfing, Gaspers, Choke Chicks, and Airwalkers.

Bestiality – *Paraphilia*
A paraphilia characterized by sexual intercourse between a person and an animal. Also called Zoophilia or Zooerasty.

- From Latin – *bestia*, a beast.
Breath Games – *Paraphilia*
   See Autoerotic Asphyxiation

Breath Play – *Paraphilia*
   See Autoerotic Asphyxiation

Choke Chicks – *Paraphilia*
   See Autoerotic Asphyxiation

Coprophilia – *Paraphilia*
   A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior involving excrement or feces; more generally, an exaggerated interest in or preoccupation with feces and their excretion. Also known as Scatting.
   ■ From Greek – *kopros*, excrement + *philos*, loving; from *philein*, to love + -ia, indicating a condition or quality.

Delilah Syndrome – *Paraphilia*
   Promiscuity in a woman motivated by a desire to render men weak and helpless. Named after the Philistine mistress of Samson who deprived him of his strength by cutting off his hair.

Down Low – *Paraphilia*
   Refers to men who publically identify as heterosexual--straight--but engage in same-sex sexual activity. These men are often in long-term heterosexual marriages or relationships with women. The men in no way perceive or identify themselves as Gay or Homosexual. A man who identifies this way would be said to be “on the Down Low,” or “on the DL.”

Dual-Role Transvestism Fetishistic – *Paraphilia*
   The wearing of clothes of the opposite sex for part of the individual's existence in order to enjoy the temporary experience of membership of the opposite sex, but without any desire for a more permanent sex change or associated surgical reassignment, and without sexual excitement accompanying the cross-dressing. Gender Identity Disorder of Adolescence or Adulthood, Nontranssexual Type.

Ecouteur – *Paraphilia*
   A person who derives sexual gratification from eavesdropping on sexual encounters between others or listening to other people speaking about sex.
   ■ From French – *écouter*, to listen.

Erotic Asphyxiation – *Paraphilia*
   See Autoerotic Asphyxiation

Fetishistic Transvestism – *Paraphilia*
   A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior involving the wearing of clothes of the opposite sex and appearing as a member of the opposite sex. Also called Transvestic Fetishism.
- From Latin – *trans*, across + *vestire*, to dress.

**Friends with Benefits – Paraphilia**
Sexual behavior practiced primarily among high school age teenagers and college-age students. These individuals make agreements with each other, individually or as a group, to engage in sexual activity with each other until such time as one or the other friend finds a steady or permanent committed relationship and sexual partner. The primary goal of Friends with Benefits is to obtain sexual satisfaction without any long-term emotional ties or obligations. (The origin of Friends with Benefits is questionable, but it seems to have emerged in the mid ‘90’s.)

**Gaspers – Paraphilia**
See Autoerotic Asphyxiation

**Golden Showers – Paraphilia**
See Urophilia

**Scopophilia – Paraphilia**
See Scopophilia

**Golden Showers – Paraphilia**
See Urophilia

**Scopophilia – Paraphilia**
See Scopophilia

**Hypoxyphilia – Paraphilia**
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior involving a dangerous and sometimes fatal form of Sexual Masochism in which self-stimulation is sought by oxygen deprivation through the use of a noose, ligature, plastic bag, or chemical substance such as amyl nitrite.
- From Greek – *hypo*, under + *oxy-*, denoting oxygen + *philos*, loving; from *phileein*, to love + -ia, indicating a condition or quality.

**Katasexualism – Paraphilia**
A generic name for the Paraphilias, Necrophilia, and Zoophilia.
- From Greek – *kata*, down + English, *sexualism*.

**Kleptolagnia – Paraphilia**
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving stealing.
- From Greek – *kleptein*, to steal + *lagniea*, lust.

**Klüver–Bucy Syndrome – Paraphilia**
A syndrome resulting from bilateral damage to the temporal lobes of the brain, characterized by increased and indiscriminate sexual activity, excessive oral behavior,
Visual Agnosia, and Hypermetamorphosis. Named after the U.S.-based German psychologist Heinrich Klüver (1898–1979) and the U.S. neurosurgeon Paul Clancy Bucy (1904–92) who first described the condition in monkeys following surgical removal of the temporal lobes.

Klysmaphilia – Paraphilia
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving enemas.
- From Greek – *klyisma*, an enema + *philos*, loving, from *phileein*, to love + *-ia*, indicating a condition or quality.

Monopede Mania – Paraphilias
See Acrotomorphilia

Monopedophila – Paraphilias
See Acrotomorphilia

Mysophilia – Paraphilia
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving filth or a filthy surrounding.
- From Greek – *klyisma*, an enema + *philos*, loving, from *phileein*, to love + *-ia*, indicating a condition or quality.

Necrophilia – Paraphilia
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving intercourse with dead bodies.
- From Greek – *nekros*, a dead body + *philos*, loving; from *phileein*, to love + *-ia*, indicating a condition or quality.

Nymphomania – Paraphilia
The nymphomaniac of legend was probably best defined by sex research pioneer Alfred Kinsey: “someone who has more sex than you do.” Although wacky theories about female sexuality have circulated since ancient times, as a medical diagnosis nymphomania is only a couple centuries old. According to Carol Groneman, author of *Nymphomania: A History* (2000), the concept of nymphomania was first laid out by the French physician Bienville in his 1771 treatise, *Nymphomania, or a Dissertation Concerning the Furor Uterinus*. Among the behaviors Bienville cited as conducive to or symptomatic of nymphomania: dwelling on impure thoughts, reading novels, and eating too much chocolate. Oh, and indulging in “secret pollutions” (masturbation).

Osphresiolagnia – Paraphilia
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving smells.
- From Greek – *osphresis*, a smell + *lagneia*, lust.

Peeping Tom – Paraphilia
Another name for a Voyeur. Named after a 13th-century English legend according to which Lady Godiva rode naked through the marketplace of Coventry in response to a promise from her husband, Leofric, Earl of Mercia, that he would reduce taxes if she did so. In a later version of the legend, all the townspeople averted their eyes except a tailor called Tom, who was struck blind for his sin.

Priapism – *Sexual Desire Disorders*
A condition resulting from a disorder within the penis or the central nervous system, characterized by prolonged erection of the penis, seldom accompanied by sexual arousal, but usually causing pain.
- From Greek – *priapizein*, to be lewd; from *Priapos Priapus*, the ancient deity personifying male fertility and generative power.

Scarfing – *Paraphilia*
See *Autoerotic Asphyxiation*

Scatting – *Paraphilia*
See *Coprophilia*

Scopophilia – *Paraphilia*
A paraphilia characterized by recurrent, intense sexual fantasies, urges, or behavior involving looking at naked bodies or other arousing stimuli. Also written Scoptophilia.
- From Greek – *skopeein*, to watch + *philos*, loving; from *phileein*, to love + *-ia*, indicating a condition or quality.

Scoptophilia – *Paraphilia*
See *Scopophilia.*

Scotophilia – *Paraphilia*
See *Scopophilia.*

Telephone Scatalogia – *Paraphilia*
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behavior involving making obscene telephone calls to nonconsenting recipients.
- From Greek – *skor, skatos*, excrement + *logos*, a word or discourse + *-ia*, indicating a condition or quality.

Undinism – *Paraphilia*
See *Urophilia*

Upskirting – *Paraphilia*
One of the latest affronts to women, Upskirting is more typically done by individuals who carry portable cameras in bags and who film up nonconsenting women’s skirts and dresses. They might then broadcast the footage on the Internet or through cell phones–there are even Upskirting Internet Resources.
Unipedophilia – *Paraphilias*
See *Acrotomorphilia*

Urophilia – *Paraphilia*
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving urinating or being urinated on. Also called Undinism, Uurolagnia, and Golden Showers.
- From Greek – *ouron*, urine + *philos*, loving; from *phileein*, to love + -ia, indicating a condition or quality.

Uurolagnia – *Paraphilia*
See *Urophilia*

Zooerasty – *Paraphilia*
See *Zoophilia*

Zoophilia – *Paraphilia*
A paraphilia characterized by recurrent sexually arousing fantasies, sexual urges, or behaviors involving erotic attraction of a person to an animal; more specifically, another name for Bestiality.
- From Greek – *zoion*, an animal + *philos*, loving; from *phileein*, to love + -ia indicating a condition or quality.
Sleep Disorders

Sleep Disorders consist of individuals with mental disorders related to problems with sleep. There are two subgroups: Dyssomnias, characterized by the amount, quality, or timing of sleep; initiating, maintaining or excessive sleepiness and, Parasomnias, characterized by the activation of the autonomic nervous system, motor system, or cognitive process required during sleep or the transition from sleep to waking.

Disorders in this Category

Dyssomnias

- Breathing-Related Sleep Disorder (Code – 780.59)
- Central Alveolar Hypoventilation Syndrome (Code – None)
- Circadian Rhythm Sleep Disorder (Code – 307.45)
- Delayed Sleep-Phase Syndrome (Code – None)
- Disorder of Excessive Somnolence (Code – None)
- Dyssomnia Not Otherwise Specified (Code – 307.47)
- Kleine-Levine Syndrome (Code – None)
- Narcolepsy (Code – 347)
- Ondine's Curse (Code – None)
- Primary Hypersomnia (Code – 307.44)
- Primary Insomnia (Code – 307.42)
- Sleep Apnea (Code – None)
- Survivor Syndrome (Code – None)

Parasomnias

- Bruxism (Code – None)
- Central Alveolar Hypoventilation Syndrome (Code – None)
- Central Sleep Apnea (Code – None)
- Dream Anxiety Disorder (Code – None)
- Night Terrors Disorders (Code – None)
- Nightmare Disorder (Code – 307.47)
- Obstructive Sleep Apnea (Code – None)
- Parasomnia Not Otherwise Specified (Code – 307.47)
- Pavor Diurnus (Code – None)
- Pavor Nocturnus (Code – None)
- Sleep Terror Disorder (Code – 307.46)
- Sleepwalking Disorder (Code – 307.46)
- Survivor Syndrome (Code – None)
Sleep Disorders Related to Another Mental Disorder

- Hypersomnia Related to Another Mental Disorder (Code – 307.44)
- Insomnia Related to Another Mental Disorder (Code – 307.42)
- REM Behavior Disorder (Code – None)

Other Sleep Disorders

- Other Sleep Disorders Due to a General Medical Condition (Code – 780.xx)
- Substance-Induced Sleep Disorder (Code – None)

Internet Resources
http://sleepdisorders.about.com/
http://www.sleepnet.com/
http://www.nhlbi.nih.gov/about/ncsdr/
http://www.neurologychannel.com/sleepdisorders/
http://www.msnbc.com/onair/nbc/nightlynews/sleep/disorders.asp?cp1=1

Movie Suggestions
- 12 Monkeys
- Cabinet of Dr. Caligari, The
- Dream Lover
- Insomnia
- My Own Private Idaho
Additional Disorders

Bruxism
The habit of grinding the teeth, either unconsciously while awake or in Stage II NREM sleep.
▪ From Greek – brychein, to gnash.

Central Sleep Apnea – Parasomias
A form of sleep Apnea, occurring usually in elderly people, in which the episodes of breathing cessation during sleep are not associated with any obstruction to the upper airway or loud snoring, but arise from cardiac or neurological disorders. U.S. spelling, “sleep apnea.”

Central Alveolar Hypoventilation Syndrome – Dysnomnias
A breathing-related sleep disorder, occurring usually in overweight people, characterized by loss of breathing control and insufficient oxygen intake, resulting in abnormally low blood oxygen level, especially during sleep, and often leading to hypersonmia or insomnia.
▪ From Latin – alveolus, a small Depression, referring to the terminal air cavities in the lungs + Greek – hypo, under + Latin – ventilare, to ventilate; from ventus, a wind.

Delayed Sleep-Phase Syndrome – Dysnomnias
One of the dyssomnias, characterized by falling asleep very late, sleep-onset insomnia, and difficulty waking up in time to meet work, school, or social demands.

Dream Anxiety Disorder – Parasomnias
See Nightmare Disorder (Pg. 222).

Disorder of Excessive Somnolence– Dyssomnias
See Narcolepsy (Pg. 213).

Hypersomnia – Dysnomnias
Excessive sleepiness usually manifested as prolonged nocturnal sleep followed by difficulty in staying awake during the day.
▪ From Greek – hyper, over + somnus, sleep + -ia, indicating a condition or quality.

Kleine-Levine Syndrome – Dyssomnias
A rare recurrent type of Primary Hypersomnia associated with as much as 20 hours of sleep, compulsive overeating, weight gain, irritability, and inappropriate sexual behavior.

Night Terrors Disorders – Parasomnias
A Parasomnia characterized by repeated awakening from sleep, usually during the first part of the night and with a scream or cry, in a state of intense fear, confused, disoriented, and without any vivid recall of a dream, unresponsive to being comforted, and with
amnesia for the episode the following morning. Also called Night Terrors Disorder or Pavor Nocturnus or, if occurring during the day, Pavor Diurnus.

Ondine's Curse – Dyssomnias
Failure from birth of central nervous system control over breathing while asleep. There are usually no breathing problems while awake. The involuntary (autonomic) control of respiration is impaired, but the voluntary control of ventilation which operates during waking hours is generally intact.

Obstructive Sleep Apnea – Parasomias
A form of sleep Apnea, occurring usually in overweight people, in which the recurrent episodes of breathing cessation during sleep are associated with obstruction to the upper airway and are followed by loud snores or gasps as breathing resumes.

Pavor Nocturnus – Parasomnias
See Sleep Terror Disorder (Pg. 287).
- From Latin – *Pavor*, fear or dread + *nocturnus*, of the night.

Pavor Diurnus – Parasomnias
A daytime counterpart of Pavor Nocturnus. A form of Sleep Terror Disorder associated with daytime sleep, usually in children.
- From Latin – *Pavor*, fear or dread + *Diurnalis*, of the day.

REM Behavior Disorder – Sleep Disorders Related to Another Mental Disorder
A condition in which REM atonia does not function during episodes of dreaming. People with this disorder thrash violently about, leap out of bed, and sometimes attack bed-partners during REM sleep. It is assumed to be due to a lesion in the subcoerulear nucleus or the magnocellular nucleus.

Sleep Apnea – Dysnomnias
A breathing-related sleep disorder characterized by recurrent episodes of breathing cessation during sleep, leading to hypersomnia during the daytime. U.S. spelling: “sleep apnea.”
- From Greek – *apnoia*, cessation of breathing, from *a-*, without + *pnein*, to breathe.

Survivor Syndrome – Dysnomnias and Parasomnias
A term introduced by the US psychiatrist Robert Jay Lifton (b. 1926) for a pattern of responses often seen in survivors of terrible ordeals, the most important symptoms being Anhedonia, Chronic Anxiety, Depression, Dyssomnias, and Nightmares.
Somatoform Disorders

Those with Somatoform Disorders are individuals with mental disorders related to somatic symptoms, also referred to as Psychosomatic. Individuals with these disorders report symptoms of a general medical condition, but there is no evidence of any diagnosable physical problem. These physical problems are sometimes referred to as idiopathic and are not produced intentionally. The symptoms cause clinically significant distress or impairment in social, occupational, or other areas of functioning.

Disorders in this Category

- Asthenia (Code – None)
- Body Dysmorphic Disorder (Code – 300.7)
- Briquet’s Syndrome (Code – None)
- Chronic Fatigue Syndrome (Code – None)
- Colitis Ulcerative (Code – None)
- Conversion Disorder (Code – 300.11)
- Conversion Hysteria (Code – None)
- Dysmorphobia (Code – None)
- Fibromyalgia Syndrome (Code – None)
- Gulf War Syndrome (Code – None)
- Hypnoid Hysteria (Code – None)
- Hypochondriasis Disorder (Code – 300.7)
- Hysteria Neurasthenia (Code – None)
- Irritable Bowel Syndrome (Code – None)
- La Belle Indifférence (Code – None)
- Lupus (Code – None)
- Medical Student Hypochondria (Code – None)
- Medical Student Syndrome (Code – None)
- Myalgic Encephalomyelitis (Code – None)
- Pain Disorder (Code – None)
- Postviral Syndrome (Code – None)
- Pseudocyesis Disorder (Code – None)
- Restless Legs Syndrome (Code – None)
- Somatization Disorder (Code – 300.81)
- Somatoform Disorder Not Otherwise Specified (Code – 300.82)
- Temporomandibular Joint Syndrome (Code – None)
- Undifferentiated Somatoform Disorder (Code – 300.82)
- Wittmaack-Ekbom’s Syndrome (Code – None)

Internet Resources

http://www.psyweb.com/Mdisord/somatd.html
http://campus.houghton.edu/orgs/psychology/abn7a/
http://www.merck.com/mrkshared/mmanual/section15/chapter186/186a.jsp
http://www.emedicine.com/med/topic3527.htm
Movie Suggestions

- 3 Women
- Agnes of God
- Altered States
- Amateur
- Anastasia
- Band of Brothers
- Bandits
- Black Friday
- Boston Strangler, The
- Captain Newman, M.D.
- Color of Night
- Cyrano de Bergerac
- Dark Mirror, The
- Dead Again
- Despair
- Devils, The
- Double Life, A
- Double Life of Veronique, The
- Dr. Jekyll and Mr. Hyde
- Exorcist, The
- Farris Bullers Day Off
- Freud, the Secret Passion
- Great Dictator
- Gulliver’s Travels
- Hannah and Her Sisters
- Home of the Brave
- Last Temptation of Christ, The
- Let There Be Light
- Lizzie
- Manchurian Candidate, The
- Mirage
- My Girl
- Overboard
- Paris, Texas
- Persona
- Piano, The
- Poison Ivy
- Possessed
- Prelude to a Kiss
- Primal Fear
- Psycho
- Raiders of the Lost Ark
- Raising Cain
- Return of Marin Guerre, The
- San Francisco
- Secret of Dr. Kildare, The
- Send Me No Flowers
- Seventh Veil, The
- Shoah
- Sister
- Sommersby
- Sorry, Wrong Number
- Spellbound
- Steppenwolf
- Suddenly, Last Summer
- Sullivan’s Travels
- Three Faces of Eve, The
- Tommy
- Twelve O’Clock High
- Unmarried Woman, An
- Up in Arms
- Vertigo,
- Voices Within: The Lives of Truddi Chase
- What About Bob?
- Whatever Happened to Baby Jane?
Additional Disorders

Asthenia
Listlessness, debility, or tendency to fatigue.
- From Greek – astheneia, weakness, from, a-, without + sthenos, strength + -ia, indicating a condition or quality.

Briquet’s Syndrome
See Somatoform Disorder (Pg. 301).

Chronic Fatigue Syndrome
A controversial disorder, first described and named in the Annals of Internal Medicine in 1988 and redefined in an influential article in the same journal in 1994; characterized by persistent or recurrent fatigue experienced for at least six months, not resulting from unusual exertion or any apparent medical cause and not significantly relieved by rest, resulting in a marked decline in occupational, educational, social, and personal activities. Four or more of the following symptoms must then also occur persistently or recurrently for at least six months after (and not before) the onset of the disorder: severe impairment of short-term memory or concentration, sore throat, tender lymph nodes, muscle pain, multiple joint pain without swelling or redness, unfamiliar types of headaches, unrefreshing sleep, and discomfort lasting more than 24 hours following physical exertion. Some authorities believe that it often follows and is perhaps caused by a viral infection. Also called Myalgic Encephalomyelitis or Postviral Syndrome.

Colitis Ulcerative
A disease that causes inflammation and sores, called ulcers, in the lining of the large intestine. The inflammation usually occurs in the rectum and lower part of the colon, but it may affect the entire colon. Ulcerative colitis rarely affects the small intestine except for the end section, called the terminal ileum. Ulcerative colitis may also be called colitis or proctitis. Theories about what causes ulcerative colitis abound, but none have been proven. The most popular theory is that the body’s immune system reacts to a virus or a bacterium by causing ongoing inflammation in the intestinal wall. People with ulcerative colitis have abnormalities of the immune system, but doctors do not know whether these abnormalities are a cause or a result of the disease. Ulcerative colitis is not caused by emotional distress or sensitivity to certain foods or food products, but these factors may trigger symptoms in some people.

Conversion Hysteria
An obsolete term for Dissociative Disorder. In psychoanalysis, Sigmund Freud (1856–1939) introduced the term in his celebrated analysis of Little Hans in an article in 1909 entitled “Analysis of a Phobia in a Five-Year-Old Boy” to denote a form of hysteria characterized by physical symptoms (paralyses, anaesthesias, blindness, deafness, and the like) and to distinguish it from forms of hysteria characterized by anxiety and phobias without physical symptoms.
Fibromyalgia Syndrome
A common and chronic disorder characterized by widespread muscle pain, fatigue, and multiple tender points. Tender points are specific places on the body—on the neck, shoulders, back, hips, and upper and lower extremities—where people with fibromyalgia feel pain in response to slight pressure.
- From Latin – *fibro*, fibrous tissue; Greek – *myo*, muscle and *algia*, pain.

Gulf War Syndrome
A disorder controversially claimed to have been contracted by soldiers involved in the Gulf War in 1991, characterized by fatigue, muscle and joint pains, headaches, memory loss, insomnia, skin complaints, Depression, and irritability, possibly caused by multiple vaccinations, nerve gas, interaction of vaccinations with anti-nerve-gas medication, or organophosphate insecticides. Compare Chronic Fatigue Syndrome. Named after the 1991 Gulf War between an international force led by the U.S. on the one side and Iraq on the other, following Iraq’s invasion of Kuwait in 1990.

Hypnoid Hysteria
In psychoanalysis, one of three types of hysteria that were distinguished in 1895 by the Austrian physician Josef Breuer (1842–1925) and Sigmund Freud (1856–1939) in *Studies on Hysteria*, supposedly originating in a state similar to a hypnotic state. However, Freud wrote: “Strangely enough, I have never in my own experience met with a genuine hypnoid hysteria. Any that I took in hand has turned into defense hysteria.” After 1895, Freud came to believe that all hysteria is defense hysteria, and he abandoned the tripartite distinction.

Hystria
Formerly, a neurosis whose principal features consists of emotional instability, repression, dissociation, physical symptoms, and vulnerability to suggestion.

Irritable Bowel Syndrome
A chronic condition of recurrent abdominal pain, with constipation or diarrhea, without any known organic cause and poorly understood.

La Belle Indifférence
An abnormal lack of concern about one’s afflictions or disabilities, characteristic of Conversion Disorders. It is more common in women than men. It also appears more often in places where people know less about medicine and psychology, for example, in developing countries rather than in industrialized ones. When this disorder occurs in a more sophisticated person, the symptoms tend to be subtler, while the symptoms are likely to be more far-fetched in a person who doesn’t know as much about medicine. The disorder occurs most frequently between adolescence and middle age.
- From French – literally, beautiful indifference.

Lupus
A chronic, long-lasting, autoimmune disease in which the immune system, for unknown reasons, becomes hyperactive and attacks normal tissue. This attack results in
inflammation and brings about symptoms. Some believe the etiology of the condition is psychological.

Medical Student Hypochondria
See Medical Student Syndrome (Pg. 418).

Medical Student Syndrome
A form of hypochondria in medical students, occasionally developing into full-blown hypochondriasis, characterized by anxiety about having one or more (often several) of the disorders that are being studied. It often occurs as students begin studying mental disorders, when they begin to believe that they are suffering from the disorders that they are reading about in textbooks, and in this form it is also found among psychology students.

Myalgic Encephalomyelitis
See Chronic Fatigue Syndrome (Pg. 416).

Neurasthenia
A mental disorder characterized by persistent and distressing complaints of exhaustion following expenditure of insignificant amounts of mental or physical effort, including the performance of everyday tasks, with such additional signs and symptoms as muscular aches and pains, tension headaches, dyssomnia, restlessness, and irritability. The word was coined by the U.S. physician George Beard (1839–83) in his book *American Nervousness: Its Causes and Consequences* (1881).

From Greek – neuron, a nerve + astheneia, weakness, from, a-, without + sthenos, strength + -ia, indicating a condition or quality.

Postviral Syndrome
See Chronic Fatigue Syndrome (Pg. 416).

Pseudocyesis
A somatoform disorder involving a phantom pregnancy, with a false belief of being pregnant together with many of the physical signs of pregnancy.

From Greek – pseudes, false + kyesis, pregnancy.

Restless Legs Syndrome
See Wittmaack-Ekbom’s (Pg. 419).

Temporomandibular Joint Syndrome
A condition in which the patient has painful temporomandibular joints, tenderness in the muscles that move the jaw, clicking of the joints, and limitation of jaw movement. Stress, resulting in clenching the jaws and grinding the teeth, is thought to be a causal factor.

Wittmaack-Ekbom’s Syndrome
A condition in which a sense of uneasiness, restlessness, and itching, often accompanied by twitching and pain, is felt in the calves of the legs when sitting or lying down,
especially in bed at night. The only relief is walking or moving the legs, which often leads to insomnia. The cause is unknown; it may be inadequate circulation, nerve damage, deficiency of iron, vitamin B₁₂, or folic acid, or a reaction to antipsychotic or antidepressant drugs. In severe cases treatment with dopamine receptor agonists or levodopa may be helpful.
Substance-Related Disorders

Those with Substance-Related Disorders are individuals with mental disorders related to problems of abnormal use of prescription and non-prescription body and mind altering substances. Each major substance category consists of two subcategories: Use Disorders and Induced Disorders. Most of the subcategories consist of Dependence, Abuse, Intoxication, and Withdrawal.

Disorders in this Category

Alcohol-Related Disorders

Alcohol Use Disorders

- Alcohol Dependence (Code – 303.90)
- Alcohol Abuse (Code – 303.00)

Alcohol-Induced Disorders

- Alcohol Intoxication Code – (303.00)
- Alcohol Withdrawal (Code – 291.81)
- Alcohol Intoxication Delirium (Code – 291.0)
- Alcohol Withdrawal Delirium (Code – 291.0)
- Alcohol-Induced Persisting Dementia (Code – 291.2)
- Alcohol-Induced Persisting Amnestic Disorder (Code – 291.1)
- Alcohol-Induced Psychotic Disorder, With Delusions (Code – 291.5)  
  With Onset During Intoxication  
  With Onset During Withdrawal
- Alcohol-Induced Psychotic Disorder, With Hallucinations (Code – 291.3)  
  With Onset During Intoxication  
  With Onset During Withdrawal
- Alcohol-Induced Mood Disorder (Code – 291.89)  
  With Onset During Intoxication  
  With Onset During Withdrawal
- Alcohol-Induced Anxiety Disorder (Code – 291.89)  
  With Onset During Intoxication  
  With Onset During Withdrawal
- Alcohol-Induced Sexual Dysfunction (Code – 291.89)  
  With Onset During Intoxication
- Alcohol-Induced Sleep Disorder (Code – 291.89)  
  With Onset During Intoxication  
  With Onset During Withdrawal
- Alcohol-Related Disorder Not Otherwise Specified (Code – 291.9) (Pg. 420)
Amphetamine (Or Amphetamine-Like Substance)-Related Disorders

Amphetamine Use Disorders

- Amphetamine Dependence (Code – 304.40)
- Amphetamine Abuse (Code – 305.70)

Amphetamine-Induced Disorders

- Amphetamine Intoxication (Code – 292.89)
- Amphetamine Withdrawal (Code – 292.00)
- Amphetamine Intoxication Delirium (Code – 292.81)
- Amphetamine-Induced Psychotic Disorder, With Delusions (Code – 292.11)
  With Onset During Intoxication
- Amphetamine-Induced Psychotic Disorder, With Hallucinations (Code – 292.12)
  With Onset During Intoxication
- Amphetamine-Induced Mood Disorder (Code – 292.84)
  With Onset During Intoxication
  With Onset During Withdrawal
- Amphetamine-Induced Anxiety Disorder (Code – 292.89)
  With Onset During Intoxication
- Amphetamine-Induced Sexual Dysfunction (Code – 292.89)
  With Onset During Intoxication
- Amphetamine-Induced Sleep Disorder (Code – 292.89)
  With Onset During Intoxication
  With Onset During Withdrawal
- Amphetamine-Related Disorder Not Otherwise Specified (Code – 292.9)

Caffeine-Related Disorders

Caffeine-Induced Disorders

- Caffeine Intoxication (Code – 305.90)
- Caffeine-Induced Anxiety Disorder (Code – 292.89)
  With Onset During Intoxication
- Caffeine-Induced Sleep Disorder (Code – 292.89)
  With Onset During Intoxication
- Caffeine-Related Disorder Not Otherwise Specified (Code – 292.9)

Cannabis-Related Disorders

Cannabis Use Disorders

- Cannabis Dependence (Code – 304.30)
- Cannabis Abuse (Code – 305.20)
Cannabis-Induced Disorders

- Cannabis Intoxication (Code – 292.89)
- Cannabis Intoxication Delirium (Code – 292.81)
- Cannabis-Induced Psychotic Disorder, With Delusions (Code – 292.11) *With Onset During Intoxication*
- Cannabis-Induced Psychotic Disorder, With Hallucinations (Code – 292.12) *With Onset During Intoxication*
- Cannabis-Induced Anxiety Disorder (Code – 292.89) *With Onset During Intoxication*
- Cannabis-Induced Disorder Not Otherwise Specified (Code – 292.9)
- Cannabis-Related Disorder Not Otherwise Specified (Code – 292.9)

Cocaine-Related Disorders

Cocaine Use Disorders

- Cocaine Dependence (Code – 304.20)
- Cocaine Abuse (Code – 305.60)

Cocaine-Induced Disorders

- Cocaine Intoxication (Code – 292.89)
- Cocaine Withdrawal (Code – 292.0)
- Cocaine Intoxication Delirium (Code – 292.81)
- Cocaine-Induced Psychotic Disorder, With Delusions (Code – 292.11) *With Onset During Intoxication*
- Cocaine-Induced Psychotic Disorder, With Hallucinations (Code – 292.12) *With Onset During Intoxication*
- Cocaine-Induced Mood Disorder (Code – 292.84) *With Onset During Intoxication and With Onset During Withdrawal*
- Cocaine-Induced Anxiety Disorder (Code – 292.89) *With Onset During Intoxication and With Onset During Withdrawal*
- Cocaine-Induced Sexual Dysfunction (Code – 292.89) *With Onset During Intoxication*
- Cocaine-Induced Sleep Disorder (Code – 292.89) *With Onset During Intoxication and With Onset During Withdrawal*
- Cocaine-Related Disorder Not Otherwise Specified (Code – 292.9)
Hallucinogen-Related Disorders

Hallucinogen Use Disorders

- Hallucinogen Dependence (Code – 304.50)
- Hallucinogen Abuse (Code – 305.30)

Hallucinogen-Induced Disorders

- Hallucinogen Intoxication (Code – 292.89)
- Hallucinogen Persisting Perception Disorder (Code – 292.89)
- Hallucinogen Intoxication Delirium (Code – 292.81)
- Hallucinogen-Induced Psychotic Disorder, With Delusions (Code 292.11) With Onset During Intoxication
- Hallucinogen-Induced Psychotic Disorder, With Hallucinations (Code – 292.12) With Onset During Intoxication
- Hallucinogen-Induced Mood Disorder (Code – 292.84) With Onset During Intoxication
- Hallucinogen-Induced Anxiety Disorder (Code – 292.89) With Onset During Intoxication
- Hallucinogen-Related Disorder Not Otherwise Specified (Code – 292.9)

Inhalants-Related Disorders

Inhalants Use Disorders

- Inhalant Dependence (Code – 304.60)
- Inhalant Abuse (Code – 305.90)

Inhalants-Induced Disorders

- Inhalant Intoxication (Code – 292.89)
- Inhalant Intoxication Delirium (Code – 292.81)
- Inhalant-Induced Persisting Dementia (Code – 292.82)
- Inhalant-Induced Psychotic Disorder, With Delusions (Code – 292.11) With Onset During Intoxication
- Inhalant-Induced Psychotic Disorder, With Hallucinations (Code – 292.12) With Onset During Intoxication
- Inhalant-Induced Mood Disorder (Code – 292.84) With Onset During Intoxication
- Inhalant-Induced Anxiety Disorder (Code – 292.89) With Onset During Intoxication
- Inhalant-Related Disorder Not Otherwise Specified (Code – 292.9)
Nicotine-Related Disorders

Nicotine Use Disorders

• Nicotine Dependence (Code – 305.10)

Nicotine-Induced Disorders

• Nicotine Withdrawal (Code – 292.00)

Opioids-Related Disorders

Opioids Use Disorders

• Opioids Dependence (Code – 304.00)
• Opioids Abuse (Code – 305.50)

Opioids-Induced Disorders

• Opioids Intoxication (Code – 292.89)
• Opioids Withdrawal (Code – 292.0)
• Opioid Intoxication Delirium (Code – 292.81)
  *With Onset During Intoxication*
• Opioid-Induced Psychotic Disorder, With Delusions (Code – 292.11)
  *With Onset During Intoxication*
• Opioid-Induced Psychotic Disorder, With Hallucinations (Code – 292.12)
  *With Onset During Intoxication*
• Opioid-Induced Mood Disorder (Code – 292.84)
  *With Onset During Intoxication*
• Opioid-Induced Sexual Dysfunction (Code – 292.89)
  *With Onset During Intoxication*
• Opioid-Induced Sleep Disorder (Code – 292.89)
• Opioid-Related Disorder Not Otherwise Specified (Code – 292.9)

Phencyclidine-Related Disorders

Phencyclidine Use Disorder

• Phencyclidine Dependence (Code – 304.90)
• Phencyclidine Abuse (Code – 305.90)

Phencyclidine-Induced Disorder

• Phencyclidine Intoxication (Code – 292.89)
• Phencyclidine Intoxication Delirium (Code – 292.81)
• Phencyclidine-Induced Psychotic Disorder, With Delusions (Code – 292.11)  
  *With Onset During Intoxication*
• Phencyclidine-Induced Psychotic Disorder, With Hallucinations (Code – 292.12)  
  *With Onset During Intoxication*
• Phencyclidine-Induced Mood Disorder (Code – 292.84)  
  *With Onset During Intoxication*
• Phencyclidine-Induced Anxiety Disorder (Code – 292.89)  
  *With Onset During Intoxication*
• Phencyclidine-Related Disorder Not Otherwise Specified (Code – 292.9)

*SEDATIVE-, HYPNOTIC-, OR ANXIOLYTIC-RELATED DISORDERS*

Sedative, Hypnotic, or Anxiolytic Use Disorders

• Sedative, Hypnotics, or Anxiolytic Dependence (Code – 304.10)
• Sedative, Hypnotics, or Anxiolytic Abuse (Code – 305.40)
• Sedative, Hypnotics, or Anxiolytic Intoxication (Code – 292.89)
• Sedative, Hypnotics, or Anxiolytic Withdrawal (Code – 292.0)
• Sedative, Hypnotic, or Anxiolytic Intoxication Delirium (Code – 292.81)
• Sedative, Hypnotic, or Anxiolytic Withdrawal Delirium (Code – 292.81)
• Sedative-, Hypnotic-, or Anxiolytic-Induced Persisting Dementia (Code – 292.82)
• Sedative, Hypnotic, or Anxiolytic Persisting Amnestic Disorder (Code – 292.83)
• Sedative-, Hypnotic, or Anxiolytic-Induced Psychotic Disorder, With Delusions (Code – 292.11)  
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
• Sedative-, Hypnotic, or Anxiolytic-Induced Psychotic Disorder, With Hallucinations (Code – 292.12)  
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
• Sedative-, Hypnotic, or Anxiolytic-Induced Mood Disorder (Code – 292.84)  
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
• Sedative-, Hypnotic, or Anxiolytic-Induced Anxiety Disorder (Code – 292.89)  
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
• Sedative-, Hypnotic, or Anxiolytic-Induced Sexual Dysfunction (Code – 292.89)  
  *With Onset During Intoxication*
• Sedative-, Hypnotic, or Anxiolytic-Induced Sleep Disorder (Code – 292.89)  
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
• Sedative-, Hypnotic, or Anxiolytic-Related Disorder Not Otherwise Specified (Code – 292.9)

*POLYSUBSTANCE-RELATED DISORDER*

Polysubstance Use Disorder
- Polysubstance Dependence (304.80) (Pg. 425)

*Other (or Unknown) Substance Related Disorders*

**Other (or Unknown) Substance Use Disorders**

- Other (or Unknown) Substance Dependence (Code – 304.90)
- Other (or Unknown) Substance Abuse (Code – 305.90)

**Other (or Unknown) Substance-Induced Disorders**

- Other (or Unknown) Substance Intoxication (Code – 292.89)
- Other (or Unknown) Substance Withdrawal (Code – 292.0)
- Other (or Unknown) Substance-Induced Delirium (Code – 292.81)
- Other (or Unknown) Substance-Induced Persisting Dementia (Code – 292.82)
- Other (or Unknown) Substance-Induced Persisting Amnestic (Code – 292.83)
- Other (or Unknown) Substance-Induced Psychotic Disorder, With Delusions (Code – 292.11)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Induced Psychotic Disorder, With Hallucinations (Code – 292.12)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Induced Mood Disorder (Code – 292.84)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Induced Anxiety Disorder (Code – 292.89)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Induced Sexual Dysfunction (Code – 292.89)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Induced Sleep Disorder (Code – 292.89)
  *With Onset During Intoxication*
  *With Onset During Withdrawal*
- Other (or Unknown) Substance-Related Disorder Not Otherwise Specified (Code–292.9)
  *Substance Disorder Not Otherwise Specified*
- Abstinence Syndrome (Code – None)
- Adipsia (Code – None)
- Alcohol Amnestic Disorder (Code – None)
- Anabolic-Androgenic Steroids (Code – None)
- Korsakoff's Syndrome (Code – None)
- Pathological Intoxication (Code – None)
- Polydipsia (Code – None)
- Street Name (Code – None)
Internet Resources
http://www.mentalhealth.com/p20-grp.html
http://omni.ac.uk/browse/mesh/D019966.html
http://www.talktothepsychiatrist.com/SUBSTANCERELATED_Disorders.htm
http://www.psychnet-uk.com/clinical_psychology/clinical_psychology_substance_related_disorders2.htm

Movie Suggestions
• 1000 Acres
• 21 Grams
• 28 Days
• Aberdeen
• Accused
• Acid House, The
• Acts of Worship
• Affliction
• African Queen, The
• All That Jazz
• American Heart
• Angela’s Ashes
• Angle Baby
• Anything but Love
• Arthur
• As You Desire Me
• At War with Home
• Awakenings
• Bad Boys
• Bad Seed
• Bad Lieutenant
• Barfly
• Basquiat
• Bastard out of Carolina
• Beautiful Girls
• Beautiful People
• Beloved Infidel
• Best Years of Our Lives, The
• Better Living Through Circuitry
• Betty Ford Story, The
• Big Lebowski, The
• Bird
• Black Tar Heroin: The Dark End of the Street
• Blind Date
• Blow
• Blue Velvet
• Bob & Carol & Ted & Alice
• Boost, The
• Born on the Fourth of July
• Born to Win
• Boston Strangler
• Bounce
• Boxer, The
• Boys on the Side
• Breakfast of Champions
• Breakfast Club
• Breakfast at Tiffany's
• Bridget Jones's Diary
• Bright Lights, Big City
• Brother's Kiss, A
• Buddy Boy
• Butcher Boy, The
• Call Me Anna
• Can't Buy Me Love
• Carnal Knowledge
• Casablanca
• Cat on a Hot Tin Roof
• Cat Ballou
• Cat's Eye
• Changing Lanes
• Chappaqua
• Child of Rage
• Children Underground
• Christiane F.
• Citizen Ruth
• City of God
• Clean and Sober
• Clockwork Orange, A
• Closer
• Cocaine Fiends, The
• Come Back Little Sheba
• Come Fill the Cup
• Connection, The
• Corner, The
• Country Girl, The
• Courage
• Cracker Factory, The
• Crossing Guard
• Crumb
• Curse of Cocaine, The
• Curse of the Starving Class
• Dancing in the Dark
• Dark Obsession
• Darkness Before Dawn
• Days of Wine and Roses, The
• Detroit Rock City
• Director: Robert Altman
• Disclosure
• Disclosure
• Divided Memories
• Divine Secrets of the Ya Ya Sisterhood, The
• Doing Time on Maple Drive
• Down in the Delta
• Dr. Jekyll and Mr. Hyde
• Dr. T and the Women
- Dream With the Fishes
- Dream Lover
- Drugstore Cowboy
- Drunks
- E.T. The Extra-Terrestrial
- East of Eden
- Easy Rider
- Ed Wood
- Educating Rita
- Elephant Man
- Equus
- Family of Strangers
- Fan
- Fat City
- Fear and Loathing in Las Vegas
- Fiona
- Fire Within, The
- Fisher King
- Floating Away
- Flowers in the Attic
- Fool for Love
- Fools Rush In
- Forrest Gump
- Fountainhead
- Frances
- Fresh Horses
- Fried Green Tomatoes
- Full Blast
- Gadjo Dilo
- Georgia
- Gervaise
- Gia
- Gina
- Girls Town
- Go Ask Alice
- God Bless the Child
- Goodfellas
- Goodfellows
- Graduate, The
- Great Man Votes, The
- Gridlock’d
- Guinevere
- Gulliver's Travels
- Half Baked
- Hand That Rocks the Cradle
- Hannah
- Harold and Kumar Go to White Castle
- Harvey
- Hatful of Rain, A
- Helter Skelter
- Henry Fool
- High Art
- Holiday Heart
- Hollywood H20
- Home of Our Own
- Home for the Holidays
- Homegrown
- Hoosiers
- Hot Spell
- How to Make an American Quilt
- Human Traffic
- Hustler
- I Never Promised You a Rose Garden
- I Don’t Buy Kisses Anymore
- I'll Cry Tomorrow
- I'm Dancing as Fast as I Can
- Ice Storm, The
- Iceman Cometh, The
- Idle Hands
- Imaginary Crimes
- In the Best Interest of the Child
- In and Out
- Innocent Sleep, The
- Inventing the Abbots
- Ironweed
- Jack the Bear
- Jacob’s Ladder
- Jennifer on my Mind
- Jesus’ Son
- Jo Dancer, Your Life is Calling
- Joe the King
- Joker is Wild
- Jungle Fever
- Keeping Secrets
- Key Largo
- Kids
- Kluge
- L.A. Confidential
- La Cucaracha
- La Femme Nikita
- Lady Gambles
- Lady Sings the Blues, The
- Last Night at the Alamo
- Last Call
- Leaving Las Vegas
- Lenny
- Less Than Zero
- Life of the Party: The Story of Beatrice
- Lonely Passion of Judith Hearne, The
- Long Day's Journey into Night
- Looking for Mister Goodbar
- Losing Isaiah
- Lost Weekend, The
- Love is the Devil
- Love Song for Bobby Fisher, A
- Love, Lies and Lullabies
- Love Story
- Love Walked In
- Luminous Motion
- Luna
- M.A.D.D.: Mothers Against Drunk Driving
- Magic Toy Maker, The
- Magnolia
- Magnificent Obsession
- Man Who Shot Liberty Valance
- Man With the Golden
Arm, The
- Margarita Happy Hour
- Marine Life
- Mary Reilly
- Mary Shelly's Frankenstein
- Mask
- Men Don't Tell
- Mildred Peirce
- Misery
- Monument Ave.
- Morning After
- Mrs. Parker and the Vicious Circle
- Murphy's Romance
- My Favorite Year
- My Left Foot
- My Name is Bill W.
- My Name is Joe
- My Name is Kate
- Naked Lunch
- Narc
- National Lampoon's Animal House
- New Jack City
- Nico Icon
- Night of the Iguana, The
- Norma Rae
- Not My Kid
- Nutty Professor
- Once Upon a Time in the West
- Once Were Warriors
- One Too Many
- Only When I Laugh
- Other Sister, The
- Outsiders
- Oxygen
- Panic in Needle Park
- Paris, Texas
- Pay It Forward
- People vs. Larry Flynt, The
- Permanent Midnight
- Platoon
- Pollack
- Postcards from the Edge
- Prince of Tides
- Proud and the Beautiful, The
- Pulp Fiction
- Pushing Tin
- Ragtime
- Rape of Love
- Rapture
- Ratcatcher
- Rebound: The Legend of Earl the Goat
- Requiem for a Dream
- Reefer Madness
- Requiem for a Dream
- Reservoir Dogs
- Restless Years
- Right to Remain Silent
- Roses, The
- Round Midnight
- Rush
- Safe Passage
- Sarah T: Portrait of a Teenage Alcoholic
- Scared Straight: Another Story
- Scarface
- Search for Signs of Intelligent Life in the Universe
- Secret Life of Zoey, The
- Seven Percent Solution, The
- Shadow Hours
- Shadrach
- Shattered Spirits
- She's So Lovely
- Shine
- Sid and Nancy
- Simpsonco
- Simple Twist of Fate
- Single Bars, Single Women
- Skin Deep
- Skins
- Sling Blade
- Small Town Ecstasy
- Smash-Up: The Story of a Woman
- Smoke Signals
- Snake Pit
- Solas
- Sophie's Choice
- Source, The
- Spun
- St. Elmo's Fire
- Stand and Deliver
- Star is Born, A
- Stardust
- Stella
- Still Crazy
- Streamers
- Stuart Saves His Family
- Sullivan's Travels
- Sweet and Lowdown
- Sweet Bird of Youth
- Sweet Nothings
- Sybil
- Synanon
- Table for Five
- Tales of Manhattan
- Tales of Ordinary Madness
- Talking With
- Taxi Blues
- Teenage Devil Doll
- Tender Mercies
- Terms of Endearment
- The Pace That Kills
- The Trip
- The American Friend
- Thelma and Louise
- Thirteen
- This Boy’s Life
- Torchsong Trilogy
- Toughlove
- Traffic
- TrafficK
- Trainspotting
Tree Grows in Brooklyn
A
Trees Lounge
True Romance
True Crime
Twenty Four Seven
Ultimate Betrayal
Under Capricorn
Under the Influence
Under the Volcano
Upside of Anger, The
Vanishing
Verdict, The

Veronika Voss
Vital Signs
Voice in the Mirror
Wasted
Welcome to the Doll House
What Ever Happened to Baby Jane
What Price Hollywood?
What's Love Got to Do with It?
When a Man Loves a Woman

Where the Day Takes You
Who’ll Stop the Rain?
Whore
Wire, The
Wired
Wizard of Oz
Woman's Room
Wonderland
Wood, The
Yellow Contraband
Zoot Suit
Additional Disorders

Abstinence Syndrome – *Substance Disorder Not Otherwise Specified*
A pattern of signs and symptoms associated with withdrawal in a drug-dependent person who is suddenly deprived of a regular supply of the drug and is forced to practice abstinence.

Adipsia – *Alcohol-Substance Use Disorders*
Absence of thirst or abstention from drinking.
- From Greek – *a-* without + *dipsa*, thirst + -ia, indicating a condition or quality.

Alcohol Amnestic Disorder – *Alcohol-Substance Use Disorders*
See Korsakoff's Psychosis (Pg. 330).

Anabolic-Androgenic Steroids – *Substance Disorder Not Otherwise Specified*
Anabolic-Androgenic Steroids are man-made substances related to male sex hormones. “Anabolic” refers to muscle-building, and “androgenic” refers to increased masculine characteristics. “Steroids” refers to the class of drugs. These drugs are available legally only by prescription, to treat conditions that occur when the body produces abnormally low amounts of testosterone, such as delayed puberty and some types of impotence. They are also prescribed to treat body wasting in patients with AIDS and other diseases that result in loss of lean muscle mass. Abuse of anabolic steroids, however, can lead to serious health problems, some irreversible.

Dipsomania – *Alcohol-Substance Use Disorders*
Intermittent pathological craving for alcohol.
- From Greek – *dipsa*, thirst + *mania*, madness + -ia, indicating a condition or quality.

Korsakoff's Psychosis – *Alcohol-Substance Use Disorders*
A mental disorder characterized by Amnesia, especially an impairment in ability to retain newly acquired information, typically accompanied by confabulation—a tendency to invent explanations to cover areas of memory loss—but with other cognitive functions usually well preserved, in contrast to Dementia. It is caused by a deficiency of thiamine (vitamin B₁) usually resulting from Alcohol Dependence. Also called or Korsakoff's Syndrome. Named after the Russian neuropsychiatrist Sergei Sergeievich Korsakoff (1854–1900) who first described it in 1887.

Korsakoff's Syndrome – *Alcohol-Substance Use Disorders*
See Korsakoff's Psychosis (Pg. 402).

Polydipsia – *Substance Disorder Not Otherwise Specified*
Excessive thirst, symptomatic of several disorders including diabetes mellitus and certain mental disorders.
- From Greek – *polys*, much or many + *dipsa*, thirst + -ia, indicating a condition or quality.

Street Name – *Substance Disorder Not Otherwise Specified*
An unofficial name by which a street drug is referred to by its users and dealers.
Multiaxial Assessment Approach

The Diagnostic and Statistical Manual of Mental Disorders uses a Multiaxial Assessment Approach to documenting an individual’s mental health status. The Multiaxial approach is taken because there are many factors that impact an individual’s mental health status. The axes are divided into five separate groups. You will find information that will enable you to identify the five groups and their primary contents below. Following the five groups I have supplied some examples Multiaxial Assessments. Use these assessments to learn more about the Multiaxial documentation of psychiatric disorders.

Axis I: Clinical Disorders: All disorders other than personality and mental retardation.

- Adjustment Disorders
- Anxiety Disorders
- Delirium, Dementia, and Amnestic and Other Cognitive Disorders
- Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
- Dissociative Disorders
- Eating Disorders
- Factitious Disorders
- Impulse-Control Disorders
- Mental Disorders Due to a General Medical Condition
- Mood Disorders
- Other Conditions That May Be a Focus of Clinical Attention
- Schizophrenia and Other Psychotic Disorders
- Sexual and Gender Identity Disorders
- Sleep Disorders
- Somatoform Disorders
- Substance-Related Disorders

Axis II: Personal Disorders and Mental Retardation: Non-clinical issues.

- Antisocial Personality Disorder
- Avoidant Personality Disorder
- Borderline Personality Disorder
- Dependent Personality Disorder
- Histrionic Personality Disorder
- Mental Retardation
- Narcissistic Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Paranoid Personality Disorder
- Personality Disorder Not Otherwise Specified
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
**Axis III**: General Medical Conditions: Medical problems in addition to psychological illness.

- Blood and Blood-Forming Organs
- Certain Conditions Originating in the Perinatal Period
- Circulatory System and Sense Organs
- Complications of Pregnancy, Childbirth, and the Purpureum
- Congenital Anomalies
- Digestive System
- Diseases of the Muscular and Skeletal Systems and Connective Tissue
- Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders
- Genitourinary
- Infectious and Parasitic Disease
- Injury and Poisoning
- Neoplasms
- Nervous System and Sense Organs
- Respiratory System
- Skin and Subcutaneous Tissue
- Symptoms, Signs, and Ill-Defined Conditions

**Axis IV**: Psychosocial and Environmental Problems: death of a loved one, new job, college, unemployment, marriage, divorce, lawsuits, homelessness, unemployment, relationships, etc.

- Economic problems.
- Educational problems.
- Housing problems.
- Occupational problems.
- Other psychosocial and environmental problems.
- Problems with access to health care services.
- Problems related to interaction with the legal system/crime.
- Problems related to the social environment.
- Problems with primary support group.

**Axis V**: Global Assessment of Functioning: the highest level of functioning during an evaluation. The Global Assessment of Functioning (GAF) Scale is rated from zero to one hundred, zero being the lowest level of functioning. This level of functioning does not include physical and environmental issues. This area of assessment is often excluded depending on the individual diagnostician. Refer to page 435 for a complete outline of the GAF Scale.
# Global Assessment of Functioning (GAF) Scale

Consider psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness. Do not include impairment in functioning due to physical (or environmental) limitations.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.</td>
</tr>
<tr>
<td>90</td>
<td>Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).</td>
</tr>
<tr>
<td>80</td>
<td>If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in schoolwork).</td>
</tr>
<tr>
<td>70</td>
<td>Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.</td>
</tr>
<tr>
<td>60</td>
<td>Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).</td>
</tr>
<tr>
<td>50</td>
<td>Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).</td>
</tr>
<tr>
<td>40</td>
<td>Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).</td>
</tr>
<tr>
<td>30</td>
<td>Behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).</td>
</tr>
<tr>
<td>20</td>
<td>Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).</td>
</tr>
<tr>
<td></td>
<td>Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.</td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>0</td>
<td>Inadequate information.</td>
</tr>
</tbody>
</table>
Multiaxial Assessment Documentation

Case: Bonnie Robertson

Axis I 300.7 Body Dysmorphic Disorder
Axis II V71.09 No Diagnosis
Axis III V71.09 No Diagnosis
Axis IV Unemployed, divorced, no insurance
Axis V GAF = 73

Case: Frederick Mason

Axis I 300.4 Dysthymic Disorder, Early Onset
302.83 Sexual Masochism
Axis II 301.22 Schizotypal Personality Disorder
Axis III V71.09 No Diagnosis
Axis IV Living alone, crime victim
Axis V GAF = 54

Case: Jeffery Larson

Axis I 307.45 Circadian Rhythm Sleep Disorder, Jet Lag Type
300.02 Generalized Anxiety Disorder
Axis II V71.09 No Diagnosis
Axis III Chronic back pain.
Axis IV None
Axis V GAF = 93

Case: Sandra Monk

Axis I V71.09 No Diagnosis
Axis II Borderline Personality Disorder with Dominant Narcissistic Features
Axis III Parkinson Disease
Axis IV Possible legal problems, high school dropout, no health insurance.
Axis V GAF=83

Case: Linda Hoffman

Axis I 292.89 Amphetamine Intoxication
Axis II 301.22 Antisocial Personality Disorder
Axis III V71.09 No Diagnosis
Axis IV No living relatives, unemployed, divorced, homeless.
Axis V GAF= 44
Glossary

The glossary consists of terms used in the mental health field. Use the glossary to get a general idea of the meaning of a term or concept. When you find the term you wish to understand, take the time to seek more information through an in-depth study of any of the number of dictionaries dedicated to the field of psychiatry.

Acalculia: impaired ability to write numbers.
Abnormal Psychology: study of malfunctioning behavior and thinking.
Acculturation: adaptation to a new culture often causing stress and anxiety.
Acculturation Stress: stress of adapting to a new culture while maintaining one’s own identity.
Acoustic-Mnestic Aphasia: impaired ability to recall lists of words or to repeat long sentences.
Active Phase of Psychosis: symptoms that alternate between psychotic and non-psychotic.
Affect: visual expressions of feeling usually briefer in duration than a mood.
   Blunted: intensity of emotional expression is significantly reduced.
   Flat: expression is missing or nearly missing.
   Inappropriate: expression is opposite to what might be expected from the situation.
   Labile: abrupt, repeated and rapid shifts of expression.
   Restricted/constricted: reduced emotional expression.
Agitation: inner tension or feelings causing motor activity beyond what might be expected.
Agnosia: failure to recognize familiar objects.
Agonist Medication: chemicals that act at a maximum level on a receptor.
Agonist/Antagonist Medication: agonistic on one receptor and antagonistically on another.
Agrammatism: impairment in ability to arrange words in their correct order.
Agraphia for Numbers: impaired ability to write numbers.
Agraphic: impaired ability to write numbers.
Ahylognosia: impaired ability to discriminate by touch such as weight, density or texture.
Alarm Reaction: a reaction to fear.
Alexia: inability to recognize or read written words or letters.
Alogia: speech and language behavior that suggests impoverished thinking.
Amnesia: memory loss.
   Anterograde: memory loss after an event.
Retrograde: memory loss before an event.

**Amnesic Aphasia:** impaired ability to retrieve words that are required for fluent speech.

**Amnesic Apraxia:** impaired ability to perform purposeful bodily movements or gestures.

**Amorphognosia:** impaired ability to recognize the size and shape of objects by touch.

**Anatomonist Medication:** chemicals prevent other chemicals from producing a physical effect.

**Anhedonia:** an inability to feel pleasure.

**Anomia:** impaired ability to name objects or representations of objects.

**Anomic Aphasia:** impaired ability to name objects or representations of objects.

**Anosognosia:** impaired ability or refusal to acknowledge one’s sensory or motor impairment.

**Anxiety:** anticipation of future danger or misfortune with dysphoria or somatic tension.

**Aphasia:** impairment of reading, writing, or speaking.

**Aphemia:** another name for Broca's aphasia.

**Aphonia:** unable to make speech sounds not related to problems of the larynx.

**Apperceptive Agnosia:** impaired ability to identify and discriminate between objects.

**Apraxic Agraphia:** impaired ability to write words in spite of an ability to spell words orally.

**Arcuate Fasciculus:** either language comprehension is impaired or the speech is unintelligible.

**Asomatognosia:** impaired ability to recognize one's own body or part of their body.

**Associative Agnosia:** impaired ability to interpret or give meaning to objects.

**Ataxia:** voluntary muscular movements are partially or completely lost.

**Ataxic Aphasia:** impaired ability to speak with intact ability to comprehend speech.

**Attachment:** strong emotional bond between two people.

**Attention:** sustained focus on a stimulus or activity.

**Auditory Agnosia:** impaired ability to recognize or identify familiar sounds or spoken words.

**Autosomal:** non-sex-linked hereditary diseases in which the defective gene is dominant.

**Autotopagnosia:** impaired ability to identify parts of one's own body.

**Avolition:** unable to begin or continue with goal-directed activities.

**Body Affect Oozing:** the expression of one’s thoughts or feels through the face or body.

**Broca's Aphasia:** impaired ability to speak with intact ability to comprehend speech.

**Cacosmia:** hallucination or illusion of a perpetually unpleasant smell in the nostrils.

**Hyperacusis:** abnormally acute hearing or painful sensitivity to sounds.

**Callosal Apraxia:** impaired ability to carry out verbal requests with the left side of the body.
Cataplexy: bilateral loss of muscle tone leading to the collapse of the body; laughter, anger, fear.

Catatonic Behavior: motor abnormalities.
  Motoric Immobility: catalepsy or stupor.
  Excessive Motor Activity: purposeless agitation.
  Extreme Negativism: resistance to instructions or attempts to be moved.
  Mutism: elective silence.
  Posturing: frozen pose.
  Echolalia: echoing of a word or phase spoken by another.
  Echopraxia: echoing of a movement made by someone.

Catatonic Features: complete immobility to bizarre postures and movements.

Catharsis: the release of pent-up emotions.

Clinical Psychologist: a state certified psychologist who focuses on mental health and research.

Cognitive Traid: negative attribution about the self, the world and the future.

Collateral Damage: emotional damage to others who experienced the effective event.

Collective Unconscious: the cumulative wisdom of a culture.

Colour Agnosia: impaired ability to recognize or identify colors.

Comorbidity: two or more disorders.

Compulsions: ritualistic actions and behaviors.

Conduction Aphasia: either language comprehension is impaired or the speech is unintelligible.

Constructional Apraxia: impaired ability to copy simple drawings or patterns.

Conversion Symptom: voluntary motor or sensory function is lost or altered.

Coping: effective ways to adapt to problems or simulations to avoid stress.

Chorea: jerky involuntary movements affecting especially the shoulders, hips, and face.

Criminal Commitment: legal commitment to a mental institution.

Critical Period: the period an organism is predisposed to behavior acquisition.

Cultural-Familial Retardation: cultural and familial cause for retardation.

Defense Mechanism: psychological process protecting the self against anxiety, stress or danger.

Delusion: incorrect belief about external reality no matter the evidence to the contrary.
  Bizarre: belief in a totally implausible phenomenon.
  Delusional Jealousy: feeling that one’s sexual partner is unfaithful.
Erotomanic: belief that another person, usually of greater importance, is in love with one.
Grandiose: inflated worth, power, knowledge, identity, or special relationship to a deity.
Mood-Congruent: delusions or hallucinations are consistent with one’s mood.
Mood-Incongruent: delusions or hallucinations are inconsistent with one’s mood.
Being Controlled: belief that one’s feelings, impulses, thoughts, or actions are under an external control.
Reference: belief that events, objects or other persons have an unusual significance.
Prosecutory – belief that one is being attacked, harassed, cheated, persecuted, or conspired against.
Somatic: problems with one’s body appearance or function.
Thought Broadcasting: belief that others can hear one’s thoughts.
Thought Insertion: belief that thoughts are being inserted into one’s brain.
**Depersonalization:** feeling detached, as if observing one’s self from outside their body.
**Derailment:** speech pattern that goes from one topic to the next although unrelated to each other.
**Derealization:** external world perceptions or experiences feel strange or unreal.
**Destructibility:** inability to maintain attention.
**Diagnostic Specifier:** a specifier used as part of a diagnosis.
**Disinhibition:** the inability to inhibit impulses.
**Disorientation:** confusion about date, time of day, season, place, or person.
**Dissociation:** consciousness, memory, identity, or environmental perception are disrupted.
**Dressing Apraxia:** impaired ability to dress.
**Dual-Diagnosis:** two or more diagnoses.
**Dynamic Aphasia:** total failure to initiate speech, but an intact ability to name objects and read.
**Dysarthria:** disturbance of muscle control causes imperfect speech articulation.
**Dyskinesia:** voluntary movements with involuntary muscle activity are distorted.
**Dysphoria:** a feeling of uneasiness, discomfort, anxiety or anguish.
**Dysprosody:** impaired ability to produce the appropriate prosody required in speech.
**Dyssomnia:** sleep and wakefulness disorders of insomnia and hypersomnia.
**Dystonia:** tonicity of muscle disorder.
**Echolalia:** senseless repetition or parroting of a word or phase spoken by another individual.
**Echopraxia:** repeating of movements made by others.
Ego Dystonic: behavior, thoughts and attitudes that are inconsistent with the total personality.

Ego Syntonic: behavior, thoughts and attitudes that are consistent with the total personality.

Electra Complex: the female child’s attraction, during the genital stage, to her father.

Ego: the mediator between the id–immediate desire–and the superego–restricting desire.

Emergency Reaction: an organism’s physiological response to threat.

Emotion-Focused Coping: managing feelings in order to reduce anxiety.

Euthanasia: mercy killing or eliminating individuals or groups by killing.

Expectancies: concerns about what will happen in the future.

Exposure Therapy: in therapy, an individual is exposed to his or her worst fears.

Expressed Emotion: the extent that family members are hostile, critical and overbearing.

Expressive Aphasia: impaired ability to speak with intact ability to comprehend speech.

Externalizing: acting-out behaviors that annoy or threaten others.

Extroversion: continuously seeking stimulation by being outgoing and overly sociable.

Finger Agnosia: impaired ability to recognize and differentiate individual fingers of either hand.

Fixation: a drive of oral fixation or attachment.

Flashback: recurrence of past memory, feeling or perception.

Flight of Ideas: accelerated speech leading to abrupt topic to topic changes.

Flight to Recovery: leaving the therapeutic milieu when confronted with the focal issue.

Flooding: in therapy, an individual is exposed to his or her worst fears.

Fluent Aphasia: either language comprehension is impaired or the speech is unintelligible.

Free Association: in therapy, an individual simply states what is on his or her mind.

Gait Apraxia: impaired ability to walk.

Gender Identity: one’s identification on one’s own maleness or femaleness.

Gender Role: attitudes, behaviors and personality that define one’s masculinity or femininity.

Gender Dysphoria: aversion towards the physical or social identity of one’s own sex.

General Adaptation Syndrome: physical deterioration in response to recurring threats.

Genotype: an individual’s genetic endowment.

Grandiosity: sense of one’s own worth, power, knowledge, importance, or identity are inflated.

Gustatory Agnosia: impaired ability to recognize or identify tastes.

Hallucination: sensory perception of something though there is no external stimuli.

    Auditory: sounds, usually voices.
Gustatory: taste.
Mood-Congruent: delusions or hallucinations are consistent with one’s mood.
Mood: Incongruent delusions or hallucinations are inconsistent with one’s mood.
Olfactory: odor.
Somatic: problems with one’s body appearance or function.
Tactile: being touched or feeling something under one’s skin.
Visual: sight.

**Haptic Agnosia:** impaired ability to recognize or identify objects by touch alone.

**Hemiballismus:** violent involuntary movement usually restricted to one arm.

**Hardiness:** a form of optimism that is negatively correlated with illness.

**Heritability:** the extent that heredity contributes to a particular disorder.

**Hopelessness:** a sense of helplessness due to negative life experiences and expectations.

**Horologagnosia:** impaired ability to tell the time.

**Hyperactivity-Impulsivity:** excessive restlessness and inability to wait one’s turn.

**Hyperacusis:** painful sound sensation.

**Hypermetamorphosis:** tendency to attend indiscriminately and react to every visual stimulus.

**Hypersomina:** excessive sleep.

**Hypertonia:** abnormally high muscle tone or tension.

**Hypnagogic:** relating to the period immediately before falling asleep.

**Hypnopomic:** relating to the semiconscious state between sleep and wakefulness.

**Hypotonia:** abnormally low muscle tone or tension

**ICD:** the International Classification of Disease.

**Id:** the part of an individual’s personality driven by pleasure and immediate desire.

**Ideas of Reference:** passing incidents or external events have great or unusual meaning.

**Ideational Apraxia:** impaired ability to repeat previously well-established actions.

**Ideational Agraphia:** inability to select appropriate letters with ability to copy written text.

**Identification:** the process of a child adopting a parent’s beliefs, ethics, values, and standards.

**Ideokinetic Apraxia:** impaired ability to imitate unfamiliar actions.

**Ideomotor Apraxia:** impaired ability to imitate unfamiliar actions.

**Illusion:** real external stimuli are misperceived or misinterpreted.

**Inattention:** the inability to concentrate.
Incoherence: speech or thinking other people can not comprehend.

Insanity: acting in a criminal manner as a result of a mental disorder.

Insomnia: difficulty falling or staying asleep.

  Initial insomnia: difficulty falling asleep.

  Middle Insomnia: waking in the middle of the night and eventually falling back to sleep.

  Terminal Insomnia: waking up before one needs to wake up.

Integrative Agnosia: recognition of perceptual forms, but unable to integrate as a whole.

Intersex Condition: intermingling of both sexes: physical, reproductive organs, sexual behavior.

Isotonia: state or condition of equal tone or tension in two or more muscles.

Jamais Vu: sudden feeling of unfamiliarity with everyday surroundings.

Jargon Aphasia: copious unintelligible speech.

Laloplegia: paralysis of the muscles of the vocal tract and not those of the tongue.

Learned Helplessness: exposure to problems or inescapable physical or emotional stress.

Left-Sided Apraxia: impaired ability to carry out verbal requests with the left side of the body.

Lexical Agraphia: impaired ability to translate spoken sounds into written form.

Libido: psychic drive or energy especially associated with the sexual instinct.

Lifetime Morbid Risk: possibility that a blood relative will acquire another relative’s disorder.

Locus of Control: the belief that events are self-controlled or externally controlled.

Logagnosia: impaired ability to understand speech with intact ability to speak fluently.

Logamnesia: impaired ability to understand speech with intact ability to speak fluently.

Macropsia: objects appear larger than they are in reality.

Magical Thinking: the belief that one will not be affected in a way that others are affected; drugs.

Mainstreaming: teaching mentally retarded and learning disabled children in regular classrooms.

Managed Care: determining who will or will not receive health care based on need.

Mediated: new learning due to internal motivational factors such as fear.

Mental Age: the functional intellectual age of an individual.

Micropsia: objects appear smaller than they are in reality.

Modeling: observational learning.

Mood: sustained and pervasive emotion usually longer in duration than affect.
Dysphoric: sadness, anxiety or irritability.
Elevated: exaggerated state of well-being, euphoria or elation.
Euthymic: normal range of mood.
Expansive: unrestrained show of emotions or feelings.
Irritable: easily annoyed or provoked to anger

**Mood-Congruent Psychotic Features**: typical themes of a depressed or manic mood.
**Mood-Incongruent Psychotic Features**: atypical themes of a depressed or manic mood.
**Motor Aphasia**: impaired ability to speak with intact ability to comprehend speech.
**Myoclonic**: Relating to or resembling an involuntary contraction of the skeletal muscles.
**Neuroses**: problematic thinking or behavior that is still based in reality.
**Neurosis**: an individual mental illness characterized by irrational or depressive thought.
**Nominal Aphasia**: a impaired ability to retrieve the names of people or things.
**Non-Fluent Aphasia**: any form of aphasia, such as Broca's Aphasia, in which speech is impaired.
**Normalization**: the deinstitutionalization of the mentally retarded to home-style living.
**Nosology**: the classification of diseases.
**Nystagmus**: involuntary rhythmic eye movements.
**Object Blindness**: impaired ability to identify objects that are clearly perceived.
**Obsessions**: irrational and uncontrollable intrusive, recurrent thoughts.
**Ocular Apraxia**: impaired ability to make eye movements.
**Oculomotor Apraxia**: impaired ability to make eye movements.
**Oedipal Conflict**: a son’s love for his mother often in conflict with the father.
**Olfactory Agnosia**: impaired ability to recognize or identify smells.
**Optic Apraxia**: impaired ability to make eye movements.
**Optic Agnosia**: impaired ability to identify objects by sight with ability to identify them by touch.
**Oral Apraxia**: impaired ability to perform actions of the mouth and tongue.
**Orthographical Agraphia**: impaired ability to translate spoken sounds into written form.
**Overvalued Idea**: belief that is unreasonable or sustained, but is not delusional in nature.
**Panic Attacks**: sudden onset of intense apprehension, fearfulness or terror.
**Paradigm**: a model or framework for a belief, concept, or idea.
**Paramimia:** impaired ability to gesture.

**Paranoid Ideation:** suspicion of being harassed, persecution or treated unfairly.

**Paraphasia:** habitual substitution of one word for another.

**Parasomnia:** abnormal physiological events during sleep or transitions in sleep-wake.

**Pathology:** abnormality; cause, nature and effects of disease.

**Personality:** long-lasting patterns of relating to and thinking about the self or the environment.

**Phobia:** persistent and irrational fear of a specific object, activity or situation.

**Phonagnosia:** impaired ability to identify people by their voices.

**Phonological Agraphia:** impaired ability to spell by sound.

**Placebo:** a benign substance used to test the effectiveness of a substance such as a drug.

**Pleasure Principle:** the desire for immediate gratification of a need as a result of the id.

**Polygenic:** a disorder arising as a result of two or more genes.

**Preconscious:** material or thoughts not immediately aware of, but that may be accessed quickly.

**Pressured Speech:** accelerated, difficult or impossible to interrupt speech.

**Prevalence:** the frequency of a particular trait or behavior in a population.

**Primary Gain:** the avoidance or the keeping of unacceptable conflicts at bay.

**Primary Reinforcers:** meeting an organism’s basic needs of food, water, and air.

**Primary-Process Thinking:** wishful thinking fantasies providing temporary biological solutions.

**Proband:** an individual with a disorder that is under investigation.

**Problem-Focused Coping:** a plan of action for dealing directly with a stressor.

**Prodromal Phase:** the first phase of psychosis marked by deterioration and negative symptoms.

**Prodrome:** early signs or symptoms of a disorder.

**Prognosis:** a prediction about the course and outcome of a disorder.

**Prognostic:** relating to prognosis; predicting something that may occur in the future.

**Prosody:** generic name for the qualities of speech involving loudness, pitch, rhythm, and tempo

**Prosopagnosia:** impaired ability to recognize or identify previously familiar faces.

**Psychiatrist:** a medical doctor trained to practice therapy, counseling and to prescribe medication.

**Psychoanalyst:** trained to identify and evaluate unconscious childhood issues and conflicts.
Psychological Autopsy: interviews with the friends and relatives of victims.

Psychologist: an individual trained to practice therapy, counseling, teaching, and research.

Psychology: study of human behavior and thinking.

Psychometrics: the science of psychological measurement.

Psychomotor Agitation: inner tension or feelings cause motor activity beyond what’s expected.

Psychomotor Retardation: movements and speech that are visibly slower than expected.

Psychosocial Stressor: life events or changes leading to a temporary or fixed mental behavior.

Psychotic: delusions or prominent hallucinations with an absence of insight.

Rapid Eye Movement Sleep: a stage of sleep occurring in progressively lengthening episodes.

Rapport: the connectedness between individuals or among group members.

Receptive Aphasia: impaired ability to understand speech, with intact ability to speak fluently.

Receptor: organ or cell that responds to external stimuli and transmits signals to a sensory nerve.

Repression: a self-defense mechanism keeping traumatic and disturbing memories unconscious.

Residual Phase: symptoms or full syndrome occurring after remission.

Residual: that which is left after a dominate or active phase of illness.

Risk Factors: factors contributing to the acquisition of a disorder or disease.

Scaffolding: assisting mentally challenged children to have higher levels of learning.

Secondary Gain: symptoms reinforced/maintained due to the sympathy and attention they elicit.

Secondary-Process Thinking: assessing new situations, future events and goals resolution.

Self-Actualization: self-transition to one’s highest potential.

Self-Concept: the sum of one’s needs, plans, desire, values, perceptions, and memories.

Self-Monitoring: awareness of one’s own behavior, noting feelings and cognitions.

Sensory Aphasia: impaired ability to understand speech with intact ability to speak fluently

Sex: male, female, or ambiguous gender.

Sexology: the scientific study of human sexual behavior.

Sign: visual or objective pathological condition.

Simultanagnosia: impaired ability to perceive more than one object at the same time.

Social Worker: individuals trained in counseling, therapy, social policy, and sociology.

Somatic: relating to the body, especially as distinct from the mind.

Spasmophemia: speech that is impaired by spasms of the muscles in the vocal tract.

Spatial Agraphia: impaired ability to arrange and orient writing appropriately on a page.
Speech Apraxia: impaired ability to speak without other language impairments.
Standard Aphasia: sparse speech with content words, but few function words.
Stereotyped Movements: nonfunctional, driven or repetitive motor movement.
Stupor: unresponsive immobility and mutism.
Suicidology: the scientific study of suicide.
Superego: the internal monitoring device the oversees individual morals, ethics and needs.
Surface Agraphia: spelling by sound coupled with an impaired ability to spell irregular words.
Sympathetic Apraxia: impaired ability to carry out verbal requests with the left side of the body.
Symptom: reported or subjective pathology.
Syndrome: a combination of signs and symptoms; disease; morbidity.
Synesthesia: a sensory experience produces another, unrelated sensory experience.
Syntactic Aphasia: impaired ability to arrange words in grammatical sequence.
Tactile Agnosia: impaired ability to recognize or identify objects by touch alone.
Tactile Aphasia: selective impairment in ability to name objects by touch alone.
Tic: involuntary, sudden, recurrent, nonrhythmic, stereotyped motor movement or vocalization.
Tolerance: the need for more chemicals to enter the system for the same desired effect.
Topagnosia: impaired ability to identify which part of one's body has been touched.
Topographagnosia: impaired ability to find one's way around, read maps, draw plans, etc.
Transcortical Motor Aphasia: impaired spontaneous speech, but intact ability to repeat language.
Transcortical Sensory Aphasia: impaired spontaneous speech.
Transformational Agnosia: impaired ability to recognize objects viewed from unusual angles.
Transitional Stress: stress arising from the shift from one developmental stage to another.
Transsexualism: persistent desire to be the opposite sex; severe gender dysphoria.
Unconscious: memories that are out of immediate awareness.
Unilateral Limb Apraxia: impaired ability to carry out verbal requests with the left side of body.
Utilitarianism: what is moral is defined as, the greatest good for the greatest number.
Visual Agnosia: impaired ability to recognize or identify visual images or stimuli.
Visual Aphasia: inability to recognize or read written words or letters.
**Visual Shape Agnosia:** impaired ability to identify and discriminate between objects.

**Visual Apperceptive Agnosia:** impaired ability to identify and discriminate between objects.

**Visuospatial Agnosia:** impaired ability to count a small number of scattered objects.

**Wernicke's Aphasia:** either language comprehension is impaired or the speech is unintelligible.

**Written Amnestic Aphasia:** impaired ability to retrieve words that are required for fluent speech.
Drugs – Street Names

Street Names are an unofficial term by which a street drug is referred to by its users and dealers.

Acid: a common street name for LSD--Lysergic Acid Diethylamide.
Angel Dust: A common street name for the depressant drug phencyclidine.
Barbs: A street name for barbiturate drugs in general.
Bennies: A street name for benzodiazepine drugs.
Candy: A street name for barbiturate drugs.
   From Old French – sucre candi, candied sugar; from Arabic – qandi, candied; from qand cane sugar; from Dravidian.
Charlie: A street name for cocaine.
China White: A street name for the drug fentanyl.
Coke: A common street name for cocaine.
Crack: A street name for an alkaloid extracted from cocaine hydrochloride salt, mixed with sodium bicarbonate, and dried into so-called rocks. It differs from other forms of cocaine inasmuch as it is easily vaporized by heat and can be inhaled to produce an extremely rapid effect. Crack is so called because it makes a crackling sound when it is heated.
Dolls: A street name for barbiturate drugs in general.
Dope: A term used for a variety of substances; more specifically, a street name for cannabis, heroin, or occasionally other drugs.
   From Dutch – doop, a sauce; from doopen, to dip.
Downers: A common street name for central nervous system depressant drugs in general. Compare uppers.
Einsteins: A street name for the stimulant designer drug Ecstasy.
Ganja: A common street name for cannabis.
   From Hindi – gaja; from Sanskrit – grñja.
Gear: A common street name for heroin.
Goofers: A street name for barbiturate drugs in general.
Grass: A common street name for cannabis, especially in the form of marijuana.

H: A common street name for heroin.

Hog: A common street name for the depressant drug phencyclidine.

Horse: A street name for heroin.

Hug Drug: A street name sometimes used for Ecstasy, because of the feelings of empathy and benevolence that it induces.

Ice: Frozen water. Also, a street name for a very pure form of methamphetamine. Because of its purity and low vaporization point, like crack cocaine it produces a rapid and powerful effect when smoked. So called because of the appearance of its crystals when seen under magnification.

Joint: A common street name for a hand-rolled cigarette containing cannabis. Joint may get its name from the American slang for penis, alluding to its appearance.

Junk: A common street name for heroin.

Mush: A street name for the liberty cap mushroom. Mush is an abbreviation of mushroom and also descriptive the psychological state that it induces.

Nebbies: A street name for the barbiturate drug pentobarbital (pentobarbitone).

Peace Pill: A common street name for the depressant drug phencyclidine. Also, PC pill.

Phennies: A common street name of the barbiturate drug phenobarbital (phenobarbitone).

Pink Lady: A street name for secobarbital (quinalbarbitone) or Seconal.

Poppers: A street name for nitrite inhalants generally or amyl nitrite in particular. The name Poppers alludes to the fact that the capsules containing it make a popping sound when they are opened.

Pot: An obsolescent street name for cannabis. Pot-head, a habitual cannabis user. Pot may come from the Mexican Indian – potiguaya, cannabis.

Purple Hearts: A street name for the barbiturate drug phenobarbital (phenobarbitone).

Red Devils: A street name for secobarbital (quinalbarbitone) or Seconal.

Reefer: An obsolescent street name for a hand-rolled cigarette containing cannabis. Reefer may come from reef, the part of a sail gathered in when there is high wind, alluding to the resemblance of a cannabis cigarette to a rolled-up sail. The term is also used to refer to marijuana generally.

Rocks: A street name for crack cocaine. Rock makes reference to its appearance.
**Roofies:** A street name for the benzodiazepine drug, Rohypnol, the “date-rape drug.”

**Skag:** A street name for heroin.

**Smack:** A common street name for heroin.

   From Yiddish – *schmeck*, heroin.

**Snow:** A street name for cocaine.

**Special K:** A common street name for the drug ketamine.

**Speed:** A common street name for amphetamine, methamphetamine, and other closely related drugs. Speed is so called because of their stimulant effects.

**Speedball:** A street name for a drug consisting of cocaine hydrochloride mixed with heroin.

**Spliff:** A common street name for a cannabis cigarette. “Spliff” is Rastafarian slang.

**Tranq:** A common street name for the depressant drug phencyclidine. “Tranq” is slang for tranquillizer.

**Uppers:** A common street name for central nervous system stimulant drugs in general.

**Weed:** Any useless or unwanted plant. Also, a common street name for cannabis, especially in the form of marijuana.

**Yellow Bullets:** A street name for the barbiturate drug pentobarbital(pentobarbitone).
The following is a complete list of phobias. Phobias are a subgroup of Anxiety Disorders. There are over 500 phobias listed in the Glossary of Phobias. I have included many existing alternate spellings.

**Ablutophobia:** Fear of washing, bathing, or cleaning.
**Acarophobia:** Fear of itching or the insects that cause itching.
**Acerophobia:** Fear of sourness or things that are sour.
**Achluophobia:** Fear of darkness or the dark.
**Acousticophobia:** Fear of noise or sound.
**Acrophobia:** Fear of heights.
**Aelurophobia:** Fear of cats.
**Aeroacrophobia:** Fear of open high places.
**Aeronausiphobia:** Fear of vomiting secondary to airsickness.
**Aerophobia:** Fear of draft, swallowing air, or airborne noxious substances.
**Agateophobia:** Fear of insanity or becoming insane.
**Agliophobia:** Fear of pain.
**Agoraphobia:** Fear of open spaces (technically, the marketplace).
**Agraphobia:** Fear of sexual abuse.
**Agrizoophobia:** Fear of wild animals.
**Agyrophobia:** Fear of crossing streets.
**Aichmophobia:** Fear of pointed objects.
**Ailurophobia:** Fear of cats.

**Albuminurophobia:** Fear of kidney disease.
**Alektorophobia:** Fear of chickens.
**Alektrophobia:** Fear of chickens.
**Algophobia:** Fear of pain.
**Algophobia:** Fear of garlic.
**Alliumphobia:** Fear of opinions or beliefs.
**Altophobia:** Fear of dust.
**Amathophobia:** Fear of riding in cars.
**Amaxophobia:** Fear of walking.
**Amaxophobia:** Fear of being or riding in vehicles.
**Amnesiphobia:** Fear of amnesia.
**Amychophobia:** Fear of scratches or being scratched.
**Anablephobia:** Fear of looking up.
**Ancraophobia:** Fear of Fresh air.
**Androphobia:** Fear of men.
**Anemophobia:** Fear of wind or air drafts.
**Anginophobia:** Fear of quinsy or other forms of sore throat.
**Anglophobia:** Fear of England, English culture, or English people.
**Angrophobia:** Fear of anger or becoming angry.
**Ankylophobia:** dread of stiff or immobile
joints.

Anthophobia: Fear of flowers.
Anthropophobia: Fear of people or society.
Antlophobia: Fear of Floods.
Anuptaphobia: Fear of staying single.
Anxiety: Fear of Anxiety.
Apeirophobia: Fear of infinity.
Aphenphosmphobia: Fear of being touched.
Apiophobia: Fear of bees.
Apiophobia: Fear of bees.
Apotemnophobia: Fear of persons with amputations.
Arachibutyrophobia: Fear of peanut butter sticking to the roof of the mouth.
Arachnophobia: Fear of spiders.
Arithmophobia: Fear of numbers.
Arsonphobia: Fear of fire or flames.
Asthenophobia: Fear of fainting or weakness.
Astrapaphobia: Fear of thunder and thunderstorms.
Astrapophobia: Fear of lightning.
Astrophobia: Fear of stars & celestial space.
Asymmetriphobia: Fear of asymmetrical things.
Ataxiophobia: Fear of ataxia (muscular incoordination).
Ataxophobia: Fear of disorder or untidiness.

Ataxophobia: Fear of disorder.
Atelophobia: Fear of imperfection.
Atephobia: Fear of ruin.
Atephobia: Fear of ruin or ruins.
Athazagoraphobia: Fear of being Forgotten, being ignored, or Forgetting.
Atomosphobia: Fear of atomic explosions.
Atychiphobia: Fear of failure.
Aulophobia: Fear of flutes.
Aurophobia: Fear of gold.
Auroraphobia: Fear of Northern lights.
Autodysomophobia: Fear of one that has a vile odor.
Automatonophobia: Fear of ventriloquist's dummies, animatronic creatures, or wax statues.
Automysophobia: Fear of dirt, especially of being contaminated by dirt.
Automysophobia: Fear or dislike of being dirty.
Automysophobia: Fear of being dirty.
Autophobia: Fear of solitude, being alone, oneself, or being by oneself.
Aviophobia: Fear of flying.
Bacillophobia: Fear of missiles.
Bacteriophobia: Fear of bacteria..
Ballistophobia: Fear of missiles or bullets.
Barophobia: Fear of gravity.
Basiphobia: Fear of inability to stand or falling.
Bathmophobia: Fear of stairs or steep
slopes; dislike or fear of walking.  
**Bathophobia:** intense dislike of bathing; fear of depth.  
**Batophobia:** Fear of heights or being close to high buildings.  
**Batophobiafear:** Fear of fresh air.  
**Batrachophobia:** Fear of amphibians, frogs, toads, newts, or salamanders.  
**Bdellophobia:** Fear of leeches.  
**Belonephobia:** Fear of pins and needles.  
**Bibliophobia:** Fear of books.  
**Blennophobia:** Fear of slime.  
**Body Dysmorphic Disorder:** Fear of having ugly or unattractive features.  
**Bogynophobia:** dread of demons, goblins, bogies, or the bogeyman.  
**Bolshephobia:** Fear of Bolsheviks.  
**Botanophobia:** Fear of plants.  
**Bromidrophobia:** Fear of bodily odor or bodily smell.  
**Brontophobia:** Fear of thunder, thunderstorms, or lightning.  
**Bufonophobia:** Fear of toads.  
**Cacophobia:** Fear of ugliness or things that are ugly.  
**Cainophobia:** Fear of newness or novelty.  
**Caligynophobia:** Fear of beautiful women.  
**Cancerophobia:** Fear of cancer.  
**Carcinomatophobia:** Fear of cancer.  
**Carcinomophobia:** Fear of cancer.  
**Carcinophobia:** Fear of cancer.  
**Cardiophobia:** Fear of heart disease or of the heart.  
**Carnophobia:** Fear of meat.  
**Cataractophobia:** Fear of being ridiculed or ridicule.  
**Catapedaphobia:** Fear of jumping from high & low places.  
**Cathisophobia:** Fear or dislike of sitting down.  
**Catoptrophobia:** Fear of mirrors.  
**Celtophobia:** Intense dislike of Celts.  
**Cenophobia:** Dislike or fear of crowds.  
**Ceraunophobia:** Fear of thunder and lightning.  
**Chaeophobias:** Fear of hair.  
**Cheimaphobia:** Fear of cold, ice, or frost.  
**Cheimaphobia:** Fear or dislike of cold.  
**Cheimatophobia:** Fear or dislike of cold.  
**Chemophobia:** Fear of chemicals or working with chemicals.  
**Cherophobia:** Fear of gaiety.  
**Chinophobia:** Fear or dislike of snow.  
**Chionophobia:** Fear of snow.  
**Chiropodia:** Fear of hands.  
**Cholerophobia:** Fear of cholera or anger.  
**Chorophobia:** Fear of dancing.  
**Chromatophobia:** Fear or dislike of wealth or money.  
**Chromatophobia:** Fear of colors.  
**Chrometophobia:** Fear or dislike of money.  
**Chromophobia:** Fear of colors.
**Chronomentrophobia:** Fear of clocks.

**Chronophobia:** Fear or discomfort concerning time.

**Cibophobia:** Fear of food.

**Claustrophobia:** Fear of enclosed, confined, or small spaces.

**Cleisiophobia:** Fear of being locked in an enclosed place.

**Cleithrophobia:** Fear of being enclosed.

**Cleptophobia:** Fear of thieves, or loss through thievery, stealing.

**Climacophobia:** Fear of stairs, climbing stairs, or falling down stairs.

**Clinophobia:** Fear or dislike of going to bed.

**Cnidophobia:** Fear of insect stings, stings, or being stung.

**Coimetrophobia:** Fear of cemeteries.

**Coitophobia:** Fear of sexual intercourse or sex.

**Cometophobia:** Fear of comets.

**Coprastasophobia:** Fear of constipation.

**Coprophobia:** Fear of excrement and feces.

**Coulrophobia:** Fear of clowns.

**Counterphobia:** Fear of the preference by a phobic for fearful situations.

**Cremnophobia:** Fear of precipices.

**Cryophobia:** Fear of extreme cold, ice, or frost.

**Crystallophobia:** Fear of glass, crystals.

**Cyberphobia:** Fear of computers or working on a computer.

**Cyphophobia:** Fear of bicycles.

**Cymophobia:** Fear of waves or wave-like motion.

**Cynophobia:** Fear of dogs, canines, or rabies.

**Cyprianophobia:** Fear of prostitutes, venereal disease, or STDs.

**Cypridophobia:** Fear of venereal disease.

**Daemonophobia:** Fear of demons or demons.

**Decidophobia:** Fear of making decisions.

**Defecaloesiophobia:** Fear of painful bowel movements.

**Deipnophobia:** Fear of dining or dinner conversation.

**Demonophobia:** Fear of spirits, demons.

**Demophobia:** dislike of crowds.

**Dendrophobia:** Fear of trees.

**Dentophobia:** Fear of dentists.

**Dermatopathophobia:** Fear of skin disease or skin lesions.

**Dermatophobia:** Fear of skin disease.

**Dextrophobia:** Fear of objects on the right side of the body.

**Diabetophobia:** Fear of diabetes.

**Didaskaleinophobia:** Fear of going to school.

**Dikephobia:** Fear or dislike of justice.

**Dinophobia:** Fear of dizziness or whirlpools.
Diplophobia: Fear of double vision.
Diplopiaphobia: Fear of double vision.
Dipsophobia: Fear of drinking.
Dishabiliophobia: Fear of undressing in front of someone.
Domatophobia: Fear of being in a house.
Doraphobia: Fear of contact with animal fur or skin.
Doxophobia: Fear of expressing opinions or of receiving praise.
Driving Phobia: Fear of driving a motorized vehicle.
Dromophobia: Fear of crossing streets.
Dutchphobia: Fear of the Netherlands, the Dutch, Dutch Culture.
Dysmorphophobia: dread of deformity, usually in others.
Dystychiphobia: Fear of accidents.
Earthquakophobia: Fear of earthquakes.
Ecclesiophobia: Fear or dislike of church.
Ecophobia: Fear of or aversion to home surroundings.
Eisoptrophobia: Fear of mirrors or of seeing oneself in a mirror.
Electrophobia: Fear of electricity.
Eleutherophobia: Fear of freedom.
Elurophobia: Fear of cats.
Emetophobia: Fear of vomiting or throwing up.
Enetophobia: Fear of needles or pins.
Enissophobia: Fear of having committed an unpardonable sin or criticism.
Entomophobia: Fear of insects or bugs.
Eosophobia: Fear of dawn or daylight.
Ephebiphobia: Fear of teenagers.
Epistaxiophobia: Fear of nosebleeds.
Epistemophobia: Fear of knowledge.
Equinophobia: Fear of horses.
Eremophobia: Fear of being by oneself or loneliness.
Ereuthophobia: Fear of red lights, blushing, or the color red.
Ergasiophobia: Fear of work, functioning, or surgeon's operating.
Ergophobia: Fear of work.
Erotophobia: Fear of sexual feelings, sexual questions, physical expression.
Euphobia: Fear of hearing good news.
Eurotophobia: Fear of the color red; fear of blushing.
Febriphobia: Fear of fever.
Francophobia: Fear of France, French people, or French culture.
Frigophobia: Fear of cold or cold things.
Galeophobia: Fear of sharks.
Gametophobia: Fear or dislike of marriage.
Gamophobia: Fear of marriage.
Geliophobia: Fear of laughter.
Geniophobia: Fear of chins.
Genuphobia: Fear of knees.
Gephyrophobia: Fear of crossing bridges.
Gerascophobia: Fear of growing old or old
people.

**Gerascophobia:** Fear of growing old.

**Germanophobia:** Fear of Germany, German people, or German culture.

**Geumaphobia:** Fear of taste.

**Geumophobia:** Fear or dislike of smells, tastes or flavors.

**Globophobia:** Fear of balloons.

**Glossophobia:** Fear of speaking in public or trying to speak.

**Graphophobia:** Fear of writing or handwriting.

**Gynaphobia:** Fear of women.

**Gynophobia:** Fear or hatred of women.

**Hadeophobia:** Fear of hell.

**Hafophobia:** Fear of hell.

**Haemaphobia:** Fear of the sight of blood.

**Hagiophobia:** Fear of saints or holy things.

**Hamartophobia:** Fear of error or sin.

**Haphophobia:** Fear of touch.

**Haptophobia:** Fear of touch.

**Harpaxophobia:** Fear of robbers or being robbed.

**Hedonophobia:** Fear of pleasure or feeling pleasure.

**Heliophobia:** Fear of sunlight; abnormal sensitivity to the effects of sunlight.

**Hellenologophobia:** Fear of Greek terms or complex scientific terminology.

**Helminthophobia:** Fear of being infested with worms.

**Hemaphobia:** Fear of blood or the sight of blood.

**Hemophobia:** Fear of the sight of blood.

**Hereiophobia:** Fear of challenges to official doctrine or of radical deviation.

**Herpetophobia:** Fear of reptiles or creepy, crawly things.

**Heterophobia:** Fear of the opposite sex.

**Hierophobia:** Fear or dislike of sacred objects, Fear of priests.

**Hippophobia:** Fear or horses.

**Hippopotomonstrosesquippedaliphobia:** Fear of long words.

**Hobophobia:** Fear of bums or beggars.

**Hodophobia:** Fear or dislike of travel especially road travel.

**Homicliphobia:** Fear of fog.

**Homilophobia:** hatred of sermons.

**Homophobia:** Fear of sameness, monotony, homosexuality, or of becoming homosexual.

**Hoplophobia:** Fear of firearms.

**Hormephobia:** Fear of shock.

**Hyalophobia:** Fear of glass.

**Hydrargyophobia:** Fear of mercurial medicines.

**Hydrophobia:** Fear of water.

**Hydrophobophobia:** Fear of rabies.

**Hydropsyche:** Fear of rabies.

**Hygrophobia:** Fear of liquids in any form especially wine, water dampness, or
moisture.

**Hylephobia:** Fear of materialism or epilepsy.

**Hylephobia:** Dislike for wood or woods.

**Hypegiaphobia:** Fear of responsibility.

**Hypengyophobia:** Fear of responsibility.

**Hypnophobia:** Fear of sleep or being hypnotized.

**Hypsophobia:** Fear of fresh air.

**Iatrophobia:** Fear of doctors or going to the doctor.

**Ichthyophobia:** Fear of fish.

**Ideophobia:** Fear of ideas.

**Illyngophobia:** Fear of vertigo or feeling dizzy when looking down.

**Insomnophobia-Insomnia:** Fear of inability to sleep.

**Iophobia:** Fear of poisons.

**Isopterophobia:** Fear of termites, insects that eat wood.

**Japanophobia:** Fear of Japanese.

**Judeophobia:** Fear of Jewish People.

**Kakorrhaphiophobia:** Fear of failure or defeat.

**Katagelophobia:** Fear or dislike of ridicule.

**Kenophobia:** Fear of voids or empty spaces.

**Kenophobia:** Fear of crowds.

**Keraunophobia:** Fear of thunder and thunderstorms.

**Kinesophobia:** Fear of movement or motion.

**Kinetophobia:** Fear or dislike of motion.

**Kleptophobia:** Fear of thieves or loss through thievery.

**Koinoniphobia:** Fear of rooms.

**Kolpophobia:** Fear of genitals, particularly female genitals.

**Koniophobia:** Fear of dust.

**Kopophobia:** Fear of fatigue.

**Kopophobia:** Fear of mental or physical examination.

**Kosmikophobia:** Fear of cosmic phenomenon.

**Kynophobia:** Fear of rabies.

**Kyphophobia:** Fear of stooping.

**Lachanophobia:** Fear of vegetables.

**Lachanophobia:** Fear of vegetables.

**Laliophobia:** Fear of talking.

**Lalophobia:** Fear of speaking.

**Lepraphobia:** Fear of leprosy.

**Leukophobia:** Fear of the color white.

**Levophobia:** Fear of objects on the left side of the body.

**Ligyrophobia:** Fear of loud noises.

**Lilapsophobia:** Fear of tornado or hurricanes.

**Limnophobia:** Fear of lakes.

**Linophobia:** Fear of string.

**Liticaphobia:** Fear of lawsuits.

**Lockiophobia:** Fear of childbirth.

**Logizomechanophobia:** Fear of computers.
Logophobia: Fear or dislike of words.
Luiphobia: Fear of syphilis.
Lunaphobia: Fear of the moon.
Lutraphobia: Fear of otters.
Lyssophobia: Fear of becoming insane.
Macrophobia: Fear of long waits.
Mageirocophobia: Fear of cooking.
Malaxophobia: Fear of love play.
Maniaphobia: Fear of insanity.
Mastigophobia: Fear of punishment.
Mechanophobia: Aversion to or fear of machinery.
Mechanophobia: Fear of machines.
Medomalacuphobia: Fear of losing an erection.
Medorthophobia: Fear of an erect penis.
Megalophobia: Fear of large things.
Melanophobia: Fear of the color black.
Melophobia: Fear of music.
Meningitophobia: Fear of brain disease.
Menophobia: Fear of menstruation.
Merinthophobia: Fear of being bound or tied up.
Metallophobia: Fear of metals.
Metathesiophobia: Fear of changes.
Meteorophobia: Fear of meteors or meteorites.
Metrophobia: Fear of poetry.
Microbiophobia: Fear of microorganisms or germs.
Microphobia: Fear of small things.
Misanthropy: A hatred of mankind; pessimistic distrust of human nature expressed in thought and behavior.
Misogyny: Extreme dislike of females.
Misophobia: Fear of dirt, especially of being contaminated by dirt.
Misosophy: hatred of wisdom.
Mnemophobia: Fear of memories.
Molysomophobia: Fear of infection.
Monopathophobia: Fear of sickness in a specific part of the body.
Monophobia: Fear of one thing.
Motorphobia: Fear of automobiles.
Mottephobia: Fear of moths.
Murophobia: Fear of mice.
Musicophobia: Dislike of music.
Musophobia: Fear of mice.
Mycopobia: Fear or aversion to mushrooms.
Myrmecophobia: Fear of ants.
Mythophobia: Fear of myths, stories, or false statements.
Myxophobia: Fear or dislike of slime.
Necrophobia: Fear of death or dead things.
Neopharmaphobia: Fear of new drugs.
Neophobia: Fear of new things.
Nephophobia: Fear of clouds.
Noctiphobia: Fear of the night.
Nomatophobia: Fear of names.
Nosocomophobia: Fear of hospitals.
Nosophobia: Fear of becoming ill.
**Nostophobia:** Fear of returning home.

**Novercaphobia:** Fear of your stepmother.

**Nucleomituphobia:** Fear of nuclear weapons.

**Nudophobia:** Fear of nudity or nakedness.

**Numerophobia:** Fear of numbers.

**Nychtophobia:** Fear of darkness or the night.

**Nyctohylophobia:** Fear of dark wooded areas or forests at night.

**Obesophobia:** Fear of gaining weight.

**Ochlophobia:** Fear of crowds or mobs.

**Ochophobia:** Fear of vehicles.

**Octophobia:** Fear of the Figure 8.

**Odontophobia:** Fear of teeth or dental surgery.

**Odynophobia:** Fear of pain.

**Oecophobia:** Fear of or aversion to home surroundings.

**Oenophobia:** Fear of wines.

**Oenophobia:** Dislike of or hatred for wine.

**Oikophobia:** Fear of or aversion to home surroundings.

**Oinophobia:** Dislike of or hatred for wine.

**Olfactophobia:** Fear or dislike of smells.

**Ombrophobia:** Fear of rain or of being rained on.

**Ommetaphobia:** Fear of eyes.

**Oneirogmophobia:** Fear of wet dreams.

**Oneirophobia:** Fear of dreams.

**Onomatophobia:** Fear of hearing a certain word or of names.

**Ophidiophobia:** Fear of snakes.

**Ophthalmophobia:** Fear of being stared at.

**Opiophobia:** Fear of medical doctor’s experience of prescribing needed pain medications for patients.

**Optophobia:** Fear of opening one's eyes.

**Ornithophobia:** Fear of birds.

**Orthophobia:** Fear of property.

**Ostracophobia:** Fear of shellfish.

**Ouranophobia:** Fear of heaven.

**Pagophobia:** Fear of ice or frost.

**Panophobia:** Fear of everything.

**Panphobia, Pantophobia:** A nonspecific fear; a state of general anxiety; fear of everything.

**Panthophobia:** Fear of suffering or disease.

**Papaphobia:** Fear or dislike of the pope or the papacy.

**Papyrophobia:** Fear of paper.

**Paralipophobia:** Fear of neglecting duty or neglecting responsibility.

**Paraphobia:** Fear of sexual perversion.

**Parasitophobia:** Fear of parasites.

**Paraskavedekatriaphobia:** Fear of Friday the 13th.

**Parthenophobia:** Fear of virgins or young girls.

**Pathophobia:** Fear of disease.

**Patroiophobia:** Fear of heredity.

**Peccatiphobia:** Fear of sinning.
Peccatophobia: Fear of sinning.
Pediculophobia: Fear of lice.
Pediophobia: Fear of dolls.
Pedophobia: Fear or dislike of children.
Peladophobia: Fear of bald people.
Peladophobia: Dread of baldness.
Pellagrophobia: Fear of pellagra.
Peniaphobia: Fear of poverty.
Phagophobia: Fear of swallowing or eating food.
Phalacrocephobia: Fear of becoming bald.
Phanmophobia: Fear of specters or phantoms.
Pharmacophobia: Fear of taking medicine or drugs.
Phasmophobia: Fear of ghosts.
Phenoglyphophobia: Fear of daylight.
Philemaphobia: Fear of kissing.
Philophobia: Fear of love or of falling in love.
Philosophophobia: Fear or dislike of philosophy or philosophers.
Phobophobia: Fear of phobias.
Phobophobia: Fear of phobias or fear itself.
Phonemophobia: Fear of thinking.
Phonophobia: Fear of noises, voices, one's own voice, or telephones.
Photalgiophobia: Fear of photalgin, the eye pain caused by light.
Photoaugliaphobia: Fear of glaring lights.
Photophobia: Fear of light.
Phronemophobia: Fear of thinking.
Phthisiophobia: Fear of tuberculosis.
Placophobia: Fear of tombstones.
Plutophobia: Fear of wealth.
Pneumatophobia: Fear of incorporeal beings, spirits, specters or phantoms.
Pnigerophobia: Fear of choking or of being smothered.
Pnigrophobia: Fear of choking or smothering.
Pogonophobia: Fear or dislike of beards.
Poinephobia: Fear of punishment.
Poliosophobia: Fear of contracting poliomyelitis.
Politicophobia: Dislike or fear of politicians.
Polyphobia: Fear of many things.
Polyphobia: Fear of many things.
Ponophobia: Fear of fatigue or of pain, especially through overworking.
Porphyrophobia: Fear of the color purple.
Potamophobia: Fear of rivers or running water.
Potophobia: Fear of alcohol or drinks.
Proctophobia: Fear of rectums.
Prosophobia: Fear of progress.
Psellismophobia: Fear of stuttering.
Psychophobia: Fear of the mind.
Psychrophobia: Fear of the cold.
Pteromerhanophobia: Fear of flying.
Pteronophobia: Fear of feathers.
Pteronophobia: Fear of being tickled by feathers.
Pupaphobia: Fear of puppets.
Pyrexiohphobia: Fear of fever.
Pyrophobia: Fear of fire.
Radiophobia: Fear of radiation or x-rays.
Ranidaphobia: Fear of frogs.
Rectophobia: Fear of rectums or rectal diseases.
Rhabdophobia: Fear of being beaten.
Rhabdophobia: Fear of being severely punished, beaten by a rod, or severely criticized; fear of magic.
Rhypophobia: Fear of filth, defecation.
Rhytiphobia: Fear of getting wrinkles.
Rupophobia: Fear of dirt.
Russophobia: Fear of Russians.
Samhainophobia: Fear of Halloween.
Satanophobia: Fear of Satan or the devil.
Scabiohphobia: Fear of scabies.
Scelerophobia: Fear of bad men or burglars.
Sciaphobia: Fear of shadows.
Sciophobia: Fear of shadows.
Scoleciphobia: Fear of worms.
Scolionophobia: Fear of school.
Scopophobia: Fear of being seen or stared at.
Scopophobia: Fear of being looked at.
Scoptophobia: Fear of blindness in visual field.
Scotophobia: Fear of darkness or the night.
Scriptophobia: Fear of writing in public.
Selachophobia: Fear of sharks.
Selaphobia: Fear of light flashes.
Selenophobia: Fear of the moon.
Seplophobia: Fear of decaying matter.
Sesquipedalophobia: Fear of long words.
Siderodromophobia: Fear of trains, railroads, or train travel.
Siderophobia: Fear of stars.
Sinistrophobia: Fear of things to the left or left-handed.
Sinophobia: Fear of China, Chinese people, or Chinese culture.
Sitiophobia: Fear of food or eating.
Soceraphobia: Fear of parents-in-law.
Social Phobia: Fear of social situations.
Sociophobia: Fear of society or people in general.
Solophobia: Fear of sunlight; abnormal sensitivity to the effects of sunlight.
Somniphobia: Fear of sleep.
Sophophobia: Fear of learning.
Soteriophobia: Fear of dependence on others.
Spacephobia: Fear of outer space.
Specrophobia: Fear of specters or phantoms.
Spectrophobia: Fear of specters or ghosts.
Spermatophobia: Fear of loss of semen.
Spheksophobia: Fear of wasps.
**Stasibasiphobia:** Fear of standing or walking.

**Stasibaphobia:** Fear or standing or walking; conviction that one cannot stand or walk.

**Statue Phobia:** Fear of statues or effigies.

**Staurophobia:** Fear of crosses or the crucifix.

**Stenophobia:** Fear of narrow things or places.

**Stygiophobia:** Fear of hell.

**Sychrophobia:** Fear or dislike of cold.

**Symbolophobia:** Fear of symbolism.

**Symmetrophobia:** Fear or dislike of symmetry.

**Syngenesophobia:** Fear of relatives.

**Tabophobia:** Fear of a wasting sickness.

**Tachophobia:** Fear of speed.

**Taeniophobia:** Fear of tapeworms.

**Taphephobia:** Fear of being buried alive or cemeteries.

**Tapinophobia:** Fear of being contagious.

**Tapinophobia:** Fear of small things.

**Taurophobia:** Fear of bulls.

**Technophobia:** Fear of technology or computers.

**Teleophobia:** Fear of definite plans or religious ceremony.

**Telephonophobia:** Fear of the telephone.

**Teratophobia:** Fear of monsters.

**Teratophobia:** Fear of bearing a deformed child, monsters, deformed people, or giving birth to a monster.

**Testophobia:** Fear of taking tests.

**Tetanophobia:** Fear of lockjaw or tetanus.

**Textophobia:** Fear of certain fabrics.

**Thaasophobia:** Fear or dislike of being idle.

**Thalassophobia:** Fear of the sea or the ocean.

**Thanatophobia:** Fear of death, dying, being buried, cremation, or entombment.

**Theatrophobia:** Fear of theaters.

**Theologicophobia:** Fear of theology.

**Theophobia:** Fear of gods or religion.

**Thermophobia:** Fear or dislike of heat.

**Thermophobia:** Fear of fever.

**Thixophobia:** Fear of touch.

**Tocophobia:** Fear of pregnancy or childbirth.

**Tokophobia:** Fear of childbirth.

**Tomophobia:** Fear of surgery or surgical operations.

**Topophobia:** Fear of certain places or situations.

**Toxicophobia:** Fear of poison or being accidently poisoned.

**Traumatophobia:** Excessive or disabling fear of war or physical injury.

**Tremophobia:** Fear of trembling.

**Trichinophobia:** Fear of trichinosis.

**Trichopathophobia:** Fear of hair.

**Trichophobia:** Fear of hair.

**Triskaidekaphobia:** Fear of the number 13.
**Tropophobia:** Fear of moving or making changes.

**Trypanophobia:** Fear of injections.

**Tyrannophobia:** Fear or hatred of tyrants.

**Urophobia:** Fear of urine or urinating.

**Vaccinophobia:** Fear of vaccines and vaccination.

**Venereophobia:** Fear of venereal disease.

**Venustraphobia:** Fear of beautiful women.

**Verminophobia:** Fear of germs.

**Vermiphobia:** Fear of worms.

**Vestiphobia:** Fear of clothing.

**Virginitiphobia:** Fear of rape.

**Vitricophobia:** Fear of step-fathers.

**Walloonphobia:** Fear of the Walloons.

**Wiccaphobia:** Fear of witches & witchcraft.

**Xanthophobia:** Fear of the color yellow or the word “yellow”.

**Xenoglossophobia:** Fear of foreign languages.

**Xenophobia:** Fear or hatred of foreigners and strange things.

**Xerophobia:** Fear of dryness and dry places, like deserts.

**Xylophobia:** Fear of wood, wooden objects, or forests.

**Xyrophobia:** Fear of razors.

**Zelophobia:** Fear of jealousy.

**Zemmiphobia:** Fear of the great mole rat.

**Zeusophobia:** Fear of God or gods.

**Zoophobia:** Fear of animals.
Manias

The following is a complete list of manias. Manias are a subgroup of Impulse Disorders (Pg. 366). There are over 140 manias listed in the Index of Manias.

Ablutomania: Mania for washing oneself.
Aboulomania: Pathological indecisiveness.
Agromania: Intense desire to be in open spaces.
Andromania: Mania for dancing.
Anglomania: Craze or obsession with England and the English.
Anthomania: Obsession with flowers.
Aphrodisiomania: Abnormal sexual interest.
Arithmomania: Obsessive preoccupation with numbers.
Balletomania: Abnormal fondness for ballet.
Bibliomania: Craze for books or reading.
Bruxomania: Compulsion for grinding teeth.
Cacodemomania: Pathological belief that one is inhabited by an evil spirit.
Catapedamania: Obsession with jumping from high places.
Chinamania: Obsession with collecting china.
Choreomania: Dancing mania or frenzy.
Clinomania: Excessive desire to stay in bed.
Copromania: Obsession with feces.

Cytheromania: Nymphomania.
Dacnomania: Obsession with killing.
Demonomania: Pathological belief that one is possessed by demons.
Dinomania: Mania for dancing.
Dipsomania: Abnormal craving for alcohol.
Discomania: Obsession for disco music.
Doramania: Obsession with owning furs.
Doromania: Obsession with giving gifts.
Drapetomania: Intense desire to run away from home.
Dromomania: Compulsive longing for travel.
Ecdemomania: Abnormal compulsion for wandering.
Egomania: Irrational self-centered attitude or self-worship.
Eleutheromania: Manic desire for freedom.
Empleomania: Mania for holding public office.
Enosimania: Pathological belief that one has sinned.
Entheomania: Abnormal belief that one is divinely inspired.
Epomania: Craze for writing epics.
Egasiomania: Excessive desire to work; ergomania, workaholism.
Ergomania: Excessive desire to work; egasiomania, workaholism.
Erotomania: Abnormally powerful sex drive.
Etheromania: Craving for ether.
Ethnomania: Obsessive devotion to one's own people.
Eulogomania: Obsessive craze for eulogies.
Flagellomania: Abnormal enthusiasm for flogging.
Florimania: Craze for flowers.
Francomania: Craze or obsession with France and the French.
Gallomania: Craze or obsession with France and the French.
Gamomania: Obsession with issuing odd marriage proposals.
Graecomania: Obsession with Greece and the Greeks.
Graphomania: Obsession with writing.
Gynaecomania: Abnormal sexual obsession with women.
Habromania: Insanity featuring cheerful delusions.
Hagiomania: Mania for sainthood.
Hellenomania: Obsession with Greece and the Greeks.
Hexametromania: Mania for writing in hexameter.
Hieromania: Pathological religious visions or delusions.
Hippomania: Obsession with horses.
Hydromania: Irrational craving for water.
Hylomania: Excessive tendency towards materialism.
Hypermania: Severe mania.
Hypomania: Minor mania.
Hysteromania: Nymphomania.
Iconomania: Obsession with icons or portraits.
Idolomania: Obsession or devotion to idols.
Infomania: Excessive devotion to accumulating facts.
Islomania: Craze or obsession for islands.
Italomania: Obsession with Italy or Italians.
Kleptomania: Irrational predilection for stealing; klopemania.
Klopemania: Kleptomania.
Logomania: Pathological loquacity.
Lypemania: Extreme pathological mournfulness.
Macromania: Delusion that objects are larger than natural size.
Megalomania: Abnormal tendency towards grand or grandiose behavior.
Melomania: Craze for music.
Methomania: Morbid craving for alcohol.
Metromania: Insatiable desire for writing verse.
Micromania: Pathological self-deprecation or belief that one is very small.
Monomania: Abnormal obsession with a
single thought or idea.

**Morphinomania:** Habitual craving or desire for morphine.

**Musomania:** Obsession with music.

**Mythomania:** Lying or exaggerating to an abnormal extent.

**Narcomania:** Uncontrollable craving for narcotics.

**Necromania:** Sexual obsession with dead bodies; necrophilia.

**Nosomania:** Delusion of suffering from a disease.

**Nostomania:** Abnormal desire to go back to familiar places.

**Nymphomania:** Excessive or crazed sexual desire.

**Oenomania:** Obsession or craze for wine.

**Oligomania:** Obsession with a few thoughts or ideas.

**Oniomania:** Mania for making purchases.

**Onomamania:** Mania for names.

**Onomatomania:** Irresistible desire to repeat certain words.

**Onychotillomania:** Compulsive picking at the fingernails.

**Opiomania:** Craving for opium.

**Opsomania:** Abnormal love for one kind of food.

**Orchidomania:** Abnormal obsession with orchids.

**Parousiamania:** Obsession with the second coming of Christ.

**Pathomania:** Moral insanity.

**Peotillomania:** Abnormal compulsion for pulling on the penis.

**Phagomania:** Excessive desire for food or eating.

**Phaneromania:** Habit of biting one’s nails.

**Pharmacomania:** Abnormal obsession with trying drugs.

**Phonomania:** Pathological tendency to murder.

**Photomania:** Pathological desire for light.

**Phyllomania:** Excessive or abnormal production of leaves.

**Phytomania:** Obsession with collecting plants.

**Planomania:** Abnormal desire to wander and disobey social norms.

**Plutomania:** Mania for money.

**Polemomania:** Mania for war.

**Politicomania:** Mania for politics.

**Polkamania:** Craze for polka dancing.

**Polymania:** Mania affecting several different mental faculties.

**Poriomania:** Abnormal compulsion to wander.

**Pornomania:** Obsession with pornography.

**Potichomania:** Craze for imitating Oriental porcelain.

**Potomania:** Abnormal desire to drink alcohol.
**Pseudomania**: Irrational predilection for lying.

**Pteridomania**: Passion for ferns.

**Pyromania**: Craze for starting fires.

**Rhinotillexomania**: Compulsive nose picking.

**Rinkomania**: Obsession with skating.

**Satyromania**: Abnormally great male sexual desire; satyriasis.

**Scribbleomania**: Obsession with scribbling.

**Sebastomania**: Religious insanity.

**Sitiomania**: Morbid aversion to food.

**Sophomania**: Delusion that one is incredibly intelligent.

**Squandermania**: Irrational propensity for spending money wastefully.

**Stampomania**: Obsession with stamp-collecting.

**Syphilomania**: Pathological belief that one is afflicted with syphilis.

**Technomania**: Craze for technology.

**Teutomania**: Obsession with Teutonic or German things.

**Thanatomania**: Belief that one has been affected by death magic, and resulting illness.

**Theatromania**: Craze for going to plays.

**Theomania**: Belief that one is a god.

**Timbromania**: Craze for stamp collecting.

**Tomomania**: Irrational predilection for performing surgery.

**Toxicomania**: Morbid craving for poisons.

**Trichotillomania**: Neurosis where patient pulls out own hair.

**Tulipomania**: Obsession with tulips.

**Typhomania**: Delirious state resulting from typhus fever.

**Typomania**: Craze for printing one’s lucubrations.

**Uranomania**: Obsession with the idea of divinity.

**Verbomania**: Craze for words.

**Xenomania**: Inordinate attachment to foreign things.

**Zoomania**: Insane fondness for animals.
Pharmaceuticals and Natural Medications

I have prepared this section to assist you in acquiring general information regarding the various pharmaceutical and natural treatment medications that are currently prescribed and suggested psychopharmaceuticals by some health care professionals.

It is imperative that you keep the following guidelines in mind:

1. The list of pharmaceuticals and natural treatment medications should be used for reference purposes only.
2. **DO NOT** take any of the listed treatments without the approval and guidance of a qualified physician or treatment facilitator. Additionally, when selecting an individual or group to help you consider a treatment intervention, make an effort to identify those whose field(s) of study qualify them to make recommendations. This approach will afford you the opportunity to work with those who have a complete and up-to-date list of all the synthetic and natural substances suggested for an individual presenting problem.
3. I am in no way directing you to select one substance over another; I am not suggesting that one product is better than another product.
4. The list is, at best, a partial list of substances available for treating various medical conditions. Due to the constant change in available treatments and the development and availability of new medications, it is virtually impossible to prepare and present a complete, up-to-date list of pharmaceutical and natural treatment medications.
5. Generic and product names are alphabetically integrated into each general diagnostic category. Those names without an extension are synthetic. Those with an extension of – Herb, are natural herbs. Those with an extension of – V/M, are vitamins and minerals. Those with an extension of – Homeopathic are homeopathic compounds
6. I am not suggesting that one treatment is any better or worse than another. Often a substance will be a successful intervention for some individuals and unsuccessful for others. It takes time to find the correct treatment intervention for each individual.
7. You should note that I have not supplied you with specific diagnostic pharmaceutical and natural treatment medications within a general category, i.e., Bipolar versus Depression versus Manic are all part of the general category of Mood Disorders. All pain medications, muscular, headache, chronic, etc., are all part of the general category of Somatoform/Pain Disorders. Additionally, I have not suggested any dosages or daily timetable intakes. This is my further attempt to encourage you to research and learn more about the treatments before deciding to take any further action.
AIDS/HIV
- Agenerase
- Asian Ginseng – Herb
- Astragalus – Herb
- AZT
- Cancidas
- Combivir
- Copegus
- Crixivan
- Diflucan
- Echinacea – Herb
- Emtriva
- Epivir
- Epivir HBV
- Famvir
- Flumadine
- Fortovase
- Fuzeon
- Ganoderma – Herb
- Garlic – Herb
- Grifulvin
- HIVID
- Hyssop
- Invirase
- Kaletra
- Lamisil Tablets
- Lexiva
- Licorice – Herb
- Mepron
- Mycostatin
- Nizoral Tablets
- Rebetol
- Rebetron
- Relegen
- Retrovir Tablets
- Reyataz
- Shiitake – Herb
- Sporanox
- St. John’s Wort – Herb
- Sustiva
- Symmetrel
- Tamiflu
- Trizivir
- Valtrex
- Vfend

Vides EC
- Viracept
- Virmune
- Virazole
- Zerit
- Zidovudine
- Zovirax

Alzheimer’s/Dementia
- Aricept
- Cognex
- Donepezil
- Exelon
- Ginkgo – Herb
- rivastigmine
- Tacrine

Anxiety Disorders
- 5-Hydroxtryptophan – V/M
- Aconitum Napellus – Homeopathic
- Aconite – Homeopathic
- Adrenal Extract – V/M
- Alprazepam
- Alprozolam
- Anafranil
- Arsenicum Album – Homeopathic
- Atarax
- Ativan
- BuSpar
- Buspirone
- Camomile – Herb
- Celexa
- Chlordiazepoxide
- Cina – Herb
- Clomipramine
- Clonazepam
- Chlorzepate
- Compazine
- Desyrel
- Diazepam

Effexor XR
- Equanil
- Fluoxetine
- Fluvoxamine
- Gelsemium – Herb
- Ginseng – Herb
- Hops – Herb
- Hydroxyzine
- Ignatia Amara – Homeopathic
- Kava Kava – Herb
- Klonopin
- Lamictal
- Lexapro
- Librium
- Lithobid
- Lorazepam
- Luvox
- Magnesium – V/M
- Meprobamate
- Miltown
- Nardil
- Norpramin
- Nux Vomica – Homeopathic
- Oxazepam
- Paroxetine
- Parnate
- Passionflower – Herb
- Paxil
- Paxil CR
- Phosphoricum
- Acidum – Homeopathic
- Prochlorperazine
- Prozac
- Pulsatilla – Homeopathic
- Remerone
- Risperdal Tablets
- Sarafem
- Sedalia – Herb
- Serax
- Sertraline
- Serzone
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<tr>
<td><strong>Skullcap – Herb</strong></td>
<td><strong>Acidophilus – V/M</strong></td>
<td><strong>Haldol</strong></td>
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<tr>
<td><strong>St. John’s Wort –</strong></td>
<td><strong>Magnesium – V/M</strong></td>
<td><strong>Haloperidol</strong></td>
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<tr>
<td><strong>Herb</strong></td>
<td><strong>Metadata CD</strong></td>
<td><strong>Thorazine</strong></td>
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<td><strong>Stelazine</strong></td>
<td><strong>Methylenidate</strong></td>
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<td><strong>Tofranil</strong></td>
<td><strong>Niacin B3 – V/M</strong></td>
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<tr>
<td><strong>Tranxene</strong></td>
<td><strong>Olive Leaf – Heb</strong></td>
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<tr>
<td><strong>Trifluoperazine</strong></td>
<td><strong>Pemoline</strong></td>
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<td><strong>Valerian – Herb</strong></td>
<td><strong>Provigil</strong></td>
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<td><strong>Valium</strong></td>
<td><strong>Ritalin LA</strong></td>
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<td><strong>Venlafaxine</strong></td>
<td><strong>Ritalin</strong></td>
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<td><strong>Vivactil</strong></td>
<td><strong>Stramouium – Homeopathic</strong></td>
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<td><strong>Vistaril</strong></td>
<td><strong>Strattera</strong></td>
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<td><strong>Wellbutrin XL</strong></td>
<td><strong>Tarentula Hispana – Homeopathic</strong></td>
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<td><strong>Xanax</strong></td>
<td><strong>Vitamin B1</strong></td>
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<td><strong>Zoloft</strong></td>
<td><strong>Vitamin B6</strong></td>
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<td><strong>Cortifoam</strong></td>
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<td><strong>– Homeopathic</strong></td>
<td><strong>Deltasone</strong></td>
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<tr>
<td><strong>Amphetamines</strong></td>
<td><strong>Dexamethasone</strong></td>
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<td><strong>Baryta Carbonica –</strong></td>
<td><strong>Dipentum</strong></td>
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<tr>
<td><strong>Homeopathic</strong></td>
<td><strong>Ela-Max 5%</strong></td>
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<tr>
<td><strong>Bifidobacterium</strong></td>
<td><strong>Entocort EC</strong></td>
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<tr>
<td><strong>Bifidum – V/M</strong></td>
<td><strong>Fibercon</strong></td>
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<tr>
<td><strong>Caffeine</strong></td>
<td><strong>Garlic – Herb</strong></td>
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<td><strong>Chromium – V/M</strong></td>
<td><strong>Hydrocortisone</strong></td>
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<td><strong>Docosahexaenoic Acid – V/M</strong></td>
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<td><strong>Evening Primrose – Heb</strong></td>
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<td><strong>Dipentum</strong></td>
<td><strong>Medrol</strong></td>
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<td><strong>Methylprednisolone</strong></td>
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<td><strong>Nux Vomica – Homeopathy</strong></td>
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<td><strong>Garlic – Herb</strong></td>
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<td><strong>Orasone</strong></td>
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<td>Xenical Adipex</td>
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**Enuresis**

- Causticum – Homeopathic
- DDAVP
- Desmopression
- Equisetum – Homeopathic
- Imipramine
- Lycopodium – Homeopathic
- Pulsatilla – Homeopathic
- Tofranil

**Fatigue**

- Adrenal Extract – V/M
- Arsenicum Album – Homeopathic
- Ashwagandha – Herb
- Asian Ginseng – Herbs
- Astragalus – Herbs
- Burdock – Herbs
- CargoVegetabllis – Homeopathic
- Chamomile – Herbs
- Chromium – V/M
- Coenzyme Q₁₀ – V/M
- Cordyceps – Herb
- Echinacea – Herb
- Evening Primrose – Herb
- Fish Oils – V/M
- Garlic – V/M
- Ginseng, Slberian – Herb
- Goldenseal – Herb
- Licorice – Herbs
- Magnesium – V/M
- Magnese – V/M
- Milk Thistle – Herbs
- N-Acetyl Cysteine – V/M
- Natrum Muriaticum – Homeopathic
- Nicotinamide Adenine Dinucleotide – V/M
- Reishi
- Schiasnadra – Herb
- Selenium
- Shiitake – Herb
- Vitamin A
- Vitamin B₅
- Vitamin B₆
- Vitamin B₁₂

**Headache**

- Advil
- Amerge
- Anolor
- Axert
- Belladonna – Homeopathy
- Blocadren
- Bryonia
- Butalbital, Codeine, Aspirin, and Caffeine
- Butalbital, Acetaminophen, and Caffeine
- Butalbital, Aspirin, and Caffeine
- Cafergot
- Cayenne – Herb

**Lupus**

- Decadron Tablets
- Deltasone
- Dexamethasone
- Hydroxychloroquine
- Medrol
Methylprednisolone
Orasone
Pediapred
Plaquenil
Prednisolone Sodium Phosphate
Prednisone
Selenium– Herb
Slippery Elm– Herb
Vitamin A– Herb
Vitamin B5– Herb
Vitamin C – Herb
Vitamin E – Herb

Male Hormones
Androderm
Androgel
Android
Halotestin
Striat
Testim
Testoderm TTS

Mood Disorders
5-Hydroxytryptophan – V/M
Acetyl-L-Carnitine – V/M
Adrenal Extract – V/M
Amitriptyline with Perphenazine
Amitriptyline
Aurum Metallicum – Homeopathic
Aventyl
Bupropion
Celexa Silvadene
Cream
Citalopram

Dehydroepiandrosterone – V/M
Depakote
Desipramine
Desyrel

DL Phenylalanine – V/M
Doxepin
Effexor
Effexor XR
Elavil
Fluoxetine
Folic Acid – V/M
Imipramine
Kall Bromatum – Homeopathic
Lamictal
Lavender – Herb
Lexapro
Lithobid
Methionine – V/M
Mirtrazapine
Mugwort – Herb
Nardil
Nefazodone
Norpramin
Nortriptyline
Pamelor
Paroxetine
Paxil CR
Paxil
Phenelzine
Phosphatidyl Serine – V/M
Pronate
Prozac
Remeron
Risperdal Tablets
Sam-e – V/M
Sarafem
Sepia – Homeopathic
Selenium – V/M
Sertraline
Serzone
Silver Sulfadiazine
Sinequan
St. John’s Wart – Herb
Surmontil
Tofranil
Trazodine

Triavil
Trimipramine
Tyrosine – V/M
Vanadyl – V/M
Venlafaxine
Vitamin B Complex – V/M
Vitamin B6 – V/M
Vitamin C – V/M
Vivactil
Wellbutrin XL
Wellbutrin
Zoloft Celexa
Zoloft
Zyprexa

Parkinson’s Disease
Artane
Benztropine
Bromocriptine
Calciun
Carbidopae with Levodopa
Cogentin
Comtan
Eldepryl
Entacaprone
Evening Primrose Oil – Herb
Iron – V/M
Licorice – Herb
Mirapex
Parlodel
Passionflower – Herb
Pramipexole
Requip
Ropinirole
Selegiline
Senemet
Tasmar
Tocapone
Trihexyphenidyl
Vitamin B
Vitamin B6
Restless Leg Syndrome
   See Wittmaack Ekbom’s

Schizophrenia/Psychotic Disorders
   Abilify
   Amitriptyline with Perphenazine
   Chlorpromazine
   Clozapine
   Clozaril
   Compazine
   Folic Acid – V/M
   Geodon
   Haldol
   Haloperidol
   Manganese – V/M
   Mellaril
   Navane
   Niacin – V/M
   Olanzapine
   Prochlorperzaine
   Prolixin
   Quetiapine
   Risperdal
   Risperdal Tablets
   Risperidone
   Seroquel
   Stelazine
   Thoridazine
   Thiothixene
   Thorazine
   Triavil
   Trifluoperazine
   Vitamin C – V/M
   Vitamin E – V/M
   Zyprexa

Golden Chamber – Herb
   Levitra
   Muse
   Viagra

Sleep Disorders
   5-Hydroxytryptophan – V/M
   Adderall
   Ambien
   Amphetamines
   Calcium – V/M
   Chamomile – Herb
   Cina – Herb
   Coffea Cruda – Homeopathic
   Concentera
   Cylert
   Dalmane
   Dextedrine
   Dextroamphetamine
   Doral
   Extazolam
   Flurazepam
   Focalin
   Halcion
   Hops – Herb
   Hydrastis Canadensis – Homeopathic
   Ignatia Amara – Homeopathic
   Kali Bichromicum – Homeopathic
   Kava Kava – Herb
   Lycopodium
   Magnexium – V/M
   Melatonin – V/M
   Metadate CD
   Methlphenidate
   Modafinil
   Nux Vomica – Homeopathic
   Passion Flower – Herb

Sexual Disorders
   Asian Ginseng – Herb
   Caverject
   Cialis
   Cibot Root – Herb
   Damiana
   Ginkgo – Herb
   Golden Chamber – Herb
   ProSom
   Provigil
   Quazepam
   Quietude – Herb
   Restoril
   Ritalin
   Samè – V/M
   Skullcap – Herb
   Sonata
   St. John’s Wort – Herb
   Strattera
   Temazepam
   Triazolam
   Valerian – Herb
   Vitamin B6 – V/M
   Zaleplon
   Zolpidem

Smoking Cessation
   Bupropion
   Chamomile – Herb
   Commit Lozenge
   Ephedra – Herb
   Habitrol
   Hops – Herb
   Lobelia Inflata – Homeopathic
   NicoDerm
   Nicotine Patches
   Nicotrol
   Nicotrol Inhaler
   Nicotrol Transdermal
   ProStep
   Valerian – Herb
   Zyban

Somatoform/Pain
   Acetaminophen
   Acetaminophen with Codeine
   Acetaminophen with Oxycodone
   Actron
   Advil
Aleve
Anaprox
Anexsia
Ansaid
Arava
Arnica
Aspirin
Aspirin-Free Anacin
Aspirin with Codeine
Avinza
Aydrocet
Azulfidine EN-tabs
Bayer Arthritis Pain Regimen, EXT STR
Bextra (off the market)
Black Cohosh – Herb
Calicum – V/M
Chamomile – Herb
Cataflam
Cayenne – Herb
Celebrex (off the market)
Choline Magnesium
Trisalicylate
Clinoril
Co-Geesic
Dantrium
Darvocet
Darvon
Darvon Compound 32
Darvon N
Daypro
Demerol
Diclofenac
Diflunisal
Dihydrocodeine,
Asprin and Caffeine
Dilaudid
Disalcid
Dolobid
Duragesic
Ecotrin
Empirin
Empirin with Codeine
Enbrel
Etodolac
Equagesic
Evening Primrose oil – Herb
Feldene
Flexeril
Flurbiprofen
Genuine Bayer
Humira
Hydrocodone with Acetaminophen
Hydromorphone with Ibuprofen
Ibuprofen
Indocin
Indomethacin
Kadian
Kali Bichromic – Homeopathy
Ketoprofen
Ketorolac
Kineret
Lioresal
Lodine
Lorcet
Lortab
Magnesium – V/M
Maxidone
Meperidien
Mestinon
Methyl Salicylate – Herb
Morphine
Motrin
Motrin IB
MS Contin
MSIR
Naprelan
Naprosyn
Naproxen
Naproxen Sodium
Natrium Muriaticum – Homeopathy
Norflex
Norgesic Forte
Nubain
Orudis
Oruvail
OXYir
Panadol
Panlor SS
Parafon Forte DSC
Pentazocine with Asprin
Percocet
Percodan
Piroxicam
Plaquenil
Prevacid Naprapac
Propoxyphene
Relafen
Rheumatrex
Ridaura
Robaxin
Rofecoxib
Roxicet
Rhus Toxicodendron – Homeopathy
Sepia – Homeopathy
Skelaxin
Soma
Soma Compound with Codine
Sulindac
Stadol NS
Synalgos DS
Talacen
Talwin Compound
Talwin NX
Tolectin
Tolmetin
Toradol
Tramadol
Trilisate
Tylenol
Tylenol Arthritis
Extended Relief
Tylenol with Codeine
Tylox
Ultram
Valium
Vicodin
Vicoprofen
Vioxx (off the market)
Vitamin A – V/M
Vitamin B Complex – V/M
Vitamin B₆ – V/M
Vitamin B₁₂ – V/M
Vitamin C – V/M
Vitamin E – V/M
Voltaren
Voltaren XR
White Willow – Herb
Zanaflex
Zinc – V/M
Zydone

**Spastic Colon**
Anazpaz
Bellatal
Bentyl
Chlordiazepoxide with Clidinium
Clindex
Dicyclomine
Donnatal
Hyoscyamine
Levbid
Levsin
Levsinex
Librax
Phenobarbital,
Hyoscyamine,
Atropine, and
Scopolamine

**Substance-Induced Disorders**
Antabuse
Burdock – Herb
Calcium – V/M
Camprol – Herb
Catnip
Chamomile – Herb
Chemet
Copral
Chromium – V/M
 Diazepam
Digibind
Echinacea – Herb
Folic Acid – V/M
Hops – Herb
Kayexalate
Lavander – Herb
Libritabs
Librium
Licorice – Herb
Magnesium – V/M
Milk Thistle – Herb
Naltrexone – Herb
Peppermint – V/M
Potassium
ReVia
Selenium – V/M
Skullcap – Herb
Suboxone
Valerian – Herb
Vitamin A – V/M
Vitamin B Complex – V/M
Vitamin C – V/M
Vitamin B₁ – V/M
Vitamin B₅ – V/M
Vitamin E – V/M
Valium
Yarrow – Herb
Zinc – V/M

**Temporomandibular Joint Syndrome**
See Somatoform/Pain Disorders

**Tic Disorders**
Abilify
Benzodiazepine
Clozaril
Compazine
Geodon
Mellaril
Haldol
Haloperidol
Hops – Herb
Prolixin
Risperdal Tabelts
Seroquel
Thorazine
Trifluoperazine
Zyprexa

**Wittmaack Ekbom’s/ Restless Leg Syndrome**
B Complex – V/M
Black Cohosh – Herb
Caffeine – V/M
Cuprum Metallicum – Homeopathic
Decongestants – V/M
Folic Acid – V/M
Iron – V/M
Passionflower – Herb
Rhus Toxicodendron – Homeopathic
Valerian – Herb
Vitamin E – V/M
Zincum Metallicum – Homeopathic
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A Psychiatric Diagnosis Primer:
An easy guide to identifying psychiatric illness

Gary Solomon, MPH, M.S.W, Ph.D.
College of Southern Nevada
700 College Drive
Henderson, Nevada 89015
1-702-651-3524
Gary.Solomon@csn.edu

Michelle Marie Kuhn
College of Southern Nevada
1-702-340-6149
Michelle.Marie.Kuhn@gmail.com
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